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The Illinois Medical Journal

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Official Journal of the Illinois State Medical Society

EDITOR — Harold M. Camp. EDITORIAL BOARD — James H. Hutton, Chairman, Frederick H. Falls, Josiah J. Moore, Edwin M. Miller, Chauncey C. Maher, Harry S. Gradle, Harry Culver, Walter Stevenson, Raymond W. McNealy.

Editorials

THE 1945 ANNUAL MEETING

At the regular March meeting of the Council of the Illinois State Medical Society it was voted unanimously to cancel all plans for the annual meeting to be held in May but to endeavor to get approval for a meeting in August. If permission is received the dates selected are August 14, 15, 16. In the event that an annual meeting is not held this year, the House of Delegates will meet in Chicago during August and all county medical societies will be notified promptly of the plans, the place of the meeting and the dates.

The annual reports will be published as usual and a copy will be sent to each member of the House of Delegates so that it may be studied before the meeting is held, and so that proper action on each report may be taken at the proper time. The chairmen of all annual meeting committees will continue to function, arranging their respective programs. If the annual meeting is not held, so far as scientific section meetings are concerned, the papers prepared will be published in the Illinois Medical Journal so that all members of the State Medical Society may read them.

The transactions of the House of Delegates will be published in the Journal early in the fall or as soon as possible following the meetings of the House. Much consideration will be given at the meeting to the men in service and every effort will be made to assist these men in every way possible as soon as they are dismissed from service and ready to re-enter private practice. Likewise those younger Illinois physicians in service who were not formerly in private practice will be given every possible aid in the selection of a desirable location.

At this time there are many communities in Illinois, large and small, where additional physicians are needed and where there will be a place for the men willing to be relocated now. With approximately 4,500 Illinois physicians in service and the majority of those remaining in civilian work in the older age brackets, it seems probable that many of these men, now overworked, will retire from practice when replacements are available. They will be willing to aid their successors in every way possible, especially those younger men who have voluntarily heeded the call of the Army, Navy and Public Health Service for medical officers during the present emergency.

As soon as decisions are made relative to the annual meeting, or of the meeting of only the House of Delegates, all county medical societies will be notified and complete information will be given through the columns of this Journal. The Illinois State Medical Society and its thousands of members are desirous of cooperating with our government and will abide by its decision when application is made for permission to hold our 1945 annual meeting.

PREPAYMENT MEDICAL CARE PLANS

At this time plans are under way in nearly every state to make a thorough study and to develop plans for medical care on a prepayment

basis. Some twelve state plans have been placed in operation and others will begin operation in the near future. The Illinois State Medical Society has a committee which has been studying this important subject since September, 1944, and much interesting information has been compiled.

On Sunday, April 22nd an all day conference was held in Chicago with members of the committee present and having as guests, representatives from similar committees or officials of plans in operation in Michigan, Wisconsin, Iowa, Missouri and Indiana. Michigan has had their Michigan Medical Service in operation since 1941! a plan has been operating in Milwaukee County, Wisconsin for approximately 18 months; new plans are now being started in Missouri and Iowa, while in Indiana the study is being continued and they propose to have a meeting of their House of Delegates in the near future to receive a final report and the recommendations of their committee.

Representatives were present from Rockford where the Winnebago County Medical Society has approved a plan operating under supervision of the society, and the insurance being issued by an insurance company. The plan in operation only a few months, is getting a good start with several thousand subscribers enlisted at this time.

The A.M.A. Council on Medical Service and Public Relations has been cooperating in the studies and the development of plans in various states, and has endeavored to aid the Illinois committee when called upon for information and advice. When this Council was formed in 1943 six directives were received from the A.M.A. House of Delegates:

(1) To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people;

(2) To inform the constituent associations and component societies of proposed changes affecting medical care in the nation;

(3) To inform constituent associations and component societies regarding the activities of the Council;

(4) To investigate matters pertaining to the economic, social and similar aspects of medical care for all the people;

(5) To study and suggest means for the distribution of medical services to the public con-

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sistent with the principles adopted by the House of Delegates, and

(6) To develop and assist committees on medical service and public relations originating within the constituent component societies of the American Medical Association. In the exercise of its functions, this Council, with the cooperation of the Board of Trustees, shall utilize the functions and personnel of the Bureau of Legal Medicine and Legislation, The Bureau of Medical Economics and the Department of Public Relations in the Headquarters Office.

At the 1944 annual meeting of the A.M.A. House of Delegates the Council on Medical Service and Public Relations recommended that there be employed a director of medical prepayment insurance with such assistants as may be necessary, and this recommendation was approved by the House. It is therefore quite obviously one of the functions of this Council to render assistance to state societies desiring to study and eventually develop a plan for their respective states to provide medical care on a prepayment basis for those in relatively low income groups.

The Illinois State Medical Society Committee will submit a report to the House of Delegates at its next meeting and will be prepared to give freely from the amount of information which has been accumulated as may be requested by the House.

The development of a plan or plans in Illinois therefore, will be subject to the orders received from the House of Delegates. Actually our Committee has been designated as a fact-finding committee, and in that capacity will submit its report in much detail when the House convenes.

THE NEED FOR PLANNING THE ECONOMIC REHABILITATION OF THE TUBERCULOUS

A great deal of thinking and planning is being done regarding post-war physical, mental and economic rehabilitation of men and women in the armed services. To the contrary, little or no planning is taking place for the physically handicapped who are serving on the home front despite their physical limitations.

As is well known, there are arrested, apparently arrested, quiescent, and even mildly active tuberculous individuals who are doing their part by taking on war jobs and working long hours in war industries. Some of these people have already relapsed, others will no doubt follow suit and become active cases, and will transmit their disease to their fellow-workers.

The public health aspect of economic rehabilitation of the tuberculous patient has not been given the consideration that it merits by those who are responsible for the control of tuberculosis. Looking back into the history of the problem, one discovers that official agencies have consistently underestimated the significance of rehabilitation; and even today comparatively few public health officials recognize its importance. Thousands of dollars are spent annually to allay symptoms and to check progress of this disease, yet the importance of appropriating funds for the purpose of safeguarding patients from relapse after discharge from the sanatorium is not appreciated.

The economic status of the majority of tuberculous patients is such that immediately after their discharge from the sanatorium they are prematurely compelled to accept full-time employment, which frequently is unsuited to their work capacity. Inevitably such premature, full-time, unsuitable work promotes a reactivation of the disease, leading to infection to the household and other contacts, thus creating a breach in the defenses against its spread in the community.

Those who are interested in the control of tuberculosis must ultimately realize that the supervision of the tuberculous individual must not end with his discharge from the sanatorium. The great number of relapses and the many deaths which occur within a relatively short time after discharge from the sanatorium make one wonder whether much of the good work of the sanatoria and a considerable amount of public funds are not being wasted.

It should be clearly brought home to the responsible agencies that to prevent infection to the workers in industry, to the community in general, and to reduce mortality, we must prevent relapses; to avoid relapses, it is imperative to provide social and economic security for the tuberculous individual after his discharge from the institution. Such security can in a large measure be achieved if, through the medium of vocational training during convalescence, the patient has been prepared to bridge the gap between the measured pace of sheltered sanatorium life and the accelerated momentum of industrial life.

It is to be hoped that from the many relapses that will unfortunately take place during the period of war, the lesson will be driven home more forcefully that the *economic rehabilitation* of the tuberculous must be a part of any program for the control of tuberculosis. No person can remain physically well if he is not economically rehabilitated to enable him to select the type of work compatible with his physical condition. It should be borne in mind that the economically maladjusted tuberculous individual remains a potential reservoir of infection and therefore a potential menace to the family, the industrial worker and the community at large. Dr. H. I. Spector, F.C.C.P., *Diseases of the Chest, Volume X, No. 2, March-April,* 1944.

Not many sounds in life, and I include all urban and rural sounds, exceed in interest a knock at the door.—*Charles Lamb*

State Department of Public Health

THE STATE PUBLIC HEALTH SERVICE

Roland R. Cross, M.D., Director of Public Health

(This is the first of a series of articles on the history of the Department.)

The official State public health agency, now known as the State Department of Public Health but formerly as the State Board of Health, is in fact the robust child and offspring of the organized medical profession of Illinois. Born of the General Assembly of 1877 it may be said to have been conceived by the Aesculapian Society of the Wabash Valley in 1856 after death in infancy had followed several previous attempts at establishing by legislation an official State health agency. From the outset it has been nurtured and guided by physicians but not always with the unqualified blessings of its natural parent. In the main, however, its policy and program have reflected the fundamental desire and purpose of the medical profession, as there is no conflict between the two in ultimate aims. Happily the pendulum has swung to the point where at present the relations between organized medicine and the Department are most cordial and cooperative, as they should be always.

The first ill-fated attempt to establish an official State health agency took place in Territorial days when in 1817 the Territorial General Assembly passed an ordinance regulating the practice of medicine. Dr. George Fisher was Speaker of the House at that session and Ninian Edwards, Territorial Governor at the time, had served out his apprenticeship in medicine. Presumably these two doctors had a great deal to do with the enactment of that first law which along with all other Territorial statutes fell by the wayside upon the creation of the State in 1818.

In 1819 the first State General Assembly passed a law, sponsored by Dr. George Cadwell, a prominent and useful citizen of that day, regulating the practice of medicine and requiring the reporting of births, deaths and diseases. Again in 1825 the General Assembly passed a law regulating the practice of medicine, the moving spirit behind which was Dr. Conrad Will. Both laws were promptly repealed by the next succeeding General Assembly, respectively.

Solid progress toward the creation of a permanent, official State health agency began in 1856 when the Aescupalian Society of the Wabash Valley, originally organized in 1846 as the Lawrenceville Aescupalian Society, appointed a committee to go before the General Assembly with a request that a law regulating the practice of medicine and requiring the registration of births, and deaths be enacted. Again in 1861 the same Society appointed a committee for the same purpose.

At the annual meeting of the Illinois State Medical Society in May, 1876, was read a communication from the Jersey County Medical Society advocating the creation of a State Board of Health for the purpose of regulating the practice of medicine and the collection of birth and death reports. On the program of the same meeting Dr. E. W. Gray of Bloomington, read a paper, addressed to the people of the State, proposing the establishment of a State Board of Health with power not only to regulate medical practice but to engage in public health service, particularly with reference to sanitation.

As a result, Dr. Gray was appointed by the Illinois State Medical Society as chairman of a

committee to memorialize the General Assembly as to the desire of the Society that a State Board of Health be created. The resolution passed by the Illinois State Medical Society reads as follows:

"Resolved, — That a committee be appointed to memorialize the next legislature on the subject of the appointment of a State Board of Health and that with proper modifications, the act by which the Board of Health of Massachusetts was inaugurated be submitted to the same as a basis for the Illinois State Board.

"Resolved, — That as members of the State Medical Society, each one shall consider himself bound to urge the propriety of a State Board of Health upon the representative from his district."

This effort led directly to the enactment in 1877 of not one law but two, the *Medical Practice Act* and the *State Board of Health Act*. The first related only to the education and licensing of physicians; the second to sanitation, the control of epidemic diseases and to the registration of births and deaths. The administration of both laws was reposed in the State Board of Health, which was officially organized on July 12, 1877.

John W. Rauch, M.D., of Chicago, a dynamic and energetic veteran of General Grant's Civil War staff and with boundless enthusiasm for public health service, was elected president of the first State Board of Health and Dr. E. W. Gray of Bloomington was selected as the executive secretary. Other members of the Board included Newton Bateman, LL.D., Anson L. Clark, M.D., William M. Chambers, M.D., J. M. Gregory, LL.D., Reuben Ludlam, M.D., and Horace Wardner, M.D.

The powers conferred on the State Board of Health were general and sweeping in character, doubtless a recognition by the General Assembly that medical and public health work is highly technical and requires specially trained personnel of sound judgment. This first public health law, which still prevails almost without change as to broadness in scope, reads in part as follows:

"The State Board of Health shall have general supervision of the interests of the health and life of citizens of the State. They shall have charge of all matters pertaining to quarantine; and shall have authority to make such rules and regulations, and such sanitary investigations as they from time to time may deem necessary for the preservation or improvement of public health, and it shall be the duty of all police officers, sheriffs, constables, and all other officers and employes of the State, to enforce such rules and regulations, so far as the efficiency and success of the Board may depend upon their official cooperation."

How the Board used its authority, discharged its responsibilities and developed into a strong, effective organization will be discussed in subsequent articles.

SAYS FACILITIES INADEQUATE FOR CARE OF CHRONICALLY ILL

Doctor Points To Need Of Well Planned And Integrated Service To Meet The Problems Of Chronic Illness

"The existing facilities in most communities for the care of the chronically ill are inadequate, and a well planned and integrated service is needed," Herman L. Kretschmer, M.D., Chicago, says in the April 21 issue of *The Journal of the American Medical Association*. Dr. Kretschmer explains that a practical program for meeting the problems of chronic illness must look ahead far into the future.

He points out that from the intensive study which American physicians have given to the problems and diseases of old age, a new department of medicine known as geriatrics has been born. "The constant growing interest and application of the advances of medicine, surgery and allied sciences," Dr. Kretschmer says, "have resulted in an extension of the life span from 42 years in 1900 to 65 years in 1944. The ever increasing number of people in the older age groups have created new problems, of which the medical profession is keenly aware. One is purely medical and has to do with chronic illness. Its prevention and treatment are receiving the serious consideration of the medical profession. The other is a social problem and has to do with employment and security. . . ."

Dr. Kretschmer sets down prevention as the first consideration in treatment. He says that "prevention of chronic illness begins with health education on proper personal hygiene, right living and suitable diet, with particular emphasis placed on the importance of an annual physical examination. This often reveals foci of infection, such as infected tonsils and teeth, which can then be removed long before the arthritis or hypertension begins. . . ."

(*Continued on page* 223)

Medical Economics

The Medical Economics Committee — Chauncey C. Maher, Chmn., 6 North Michigan Avenue, Chicago, Edwin S. Hamilton, V. Thomas Austin, Emmet B. Bay, Jay McDonald Milligan, Jacob M. Mora, George Halperin, Marie Wessels, Thomas C. Browning, Roland R. Cross, Milton E. Bitter, Edwin F. Hirsch, Ford Hick, Lt. Col. MC, William J. Bryan, John R. Vonachen.

THE DINGELL BILL

The Dingell Bill (H. R. 395) was introduced in the House of Representatives of the United States Congress, January 3, 1945 by Rep. Dingell of Michigan. In the 78th Congress, on June 3, 1943, Senator Wagner of New York and Senator Murray of Montana introduced a similar bill in the Senate (S.R. 1161), and Rep. Dingell introduced the same bill in the House (H.R. 2861). These identical proposals are commonly known as the Wagner-Murray-Dingell Bill.

The Dingell Bill (H.R. 395) (and its antecedents) have their origin in the British Report of Sir William Beveridge reviewed in this Journal in February. The similarity of the British Report and the American Bill are unmistakable.

The copy of the bill, referred to the Ways and Means Committee, indicates that it is: "To provide for the general welfare; to alleviate the economic hazards of old age, premature death, disability, sickness, unemployment, and dependency; to amend and extend the provisions of the Social Security Act; to establish a Unified National Social Insurance System; to extend the coverage, and to protect and extend the social-security rights of individuals in the military service; to provide insurance benefits for workers permanently disabled; to establish a Federal system of unemployment compensation, temporary disability, and maternity benefits; to establish a national system of public employment offices; to establish a Federal system of medical and hospitalization benefits; to encourage and aid the advancement of knowledge and skill in the provision of health services and in the prevention of sickness, disability, and premature death; to enable the several States to make more adequate provision for the needy aged, the blind, dependent children, and other needy persons; to enable the States to establish and maintain a comprehensive public assistance program; and to amend the Internal Revenue Code."

The medical and insurance benefits are the most important parts of the bill involving the medical profession. As physicians, however, we are also concerned with the old age retirement, the permanent and temporary disability benefits, and the maternity insurance benefits as these are of a medical nature.

The salient features of the bill include provisions that the "Surgeon General of the Public Health Service is hereby authorized and directed to take all necessary and practical steps to arrange for the availability of the benefits provided . . . to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any State or political subdivision thereof — institution — private persons, to utilize their services and facilities, and to pay fair, reasonable, and equitable compensation for such facilities —." The Bill also provides for an "Advisory Medical and Hospital Council — to consist of the Surgeon General and 16 members to be appointed by the Surgeon General. The sixteen members shall be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical services and education —" "The Council is authorized to advise the Surgeon General" on various professional activities.

Under "Guiding Principles and Provisions for Administration" the bill indicates (1) physicians

may qualify for service if they are licensed by a State, (2) the individual entitled to receive benefits shall be permitted to select the physician (except specialists), subject to the consent of the general practitioner, (3) lists of general practitioners shall be published in each area by the Surgeon General. (4) Specialists are to be designated by the Surgeon General — "after consultation with the Council and utilizing standard and certifications developed by competent professional agencies" and (5) "Special Services shall be ordinarily available only on the advice of the general practitioner." (6) "The methods of administration, including the methods of making payments to practitioners, shall ensure the prompt and efficient care of individuals entitled to benefits; promote personal relationships between physician and patient; —" (7) Payments are to be made on a fee schedule approved by the Surgeon General, or a per capita basis, or a salary basis, whole or part time, or a combination of these. The Surgeon General shall publish a list of participating hospitals and provision is made for their selection.

The contributions to underwrite this type of medical and hospital service is specified as 12% of wages, 6% to be paid by the employer and 6% to be paid by the employee. This fund includes retirement, sickness or accident disability, and death benefits.

The Bill also provides a number of other features such as post-graduate education, research grants, dental and nursing services with provisions for administration. The possibilities of abuses are also considered and potential remedies are suggested.

The construction of the Dingell Bill has been criticized by both its opponents and proponents and many who feel that it would not solve the medical problems of the United States. It implies that the remedy lies in passing a law which places the majority of physicians, hospitals, nurses, pharmacists, and other medical personnel under political jurisdiction. That this tremendous political responsibility should be vested in a *single man* (*Surgeon General*) with administrative powers limited only by an *Advisory Council* seems undemocratic. The Dingell Bill represents an extreme viewpoint, copied from our English neighbors, who have under consideration the Beveridge Report, suggesting a lack of original thinking on our part.

The conservative and democratic solution of our medical problem is a continuation of reforms carried on by the medical profession. The physicians themselves, not government legislation, are responsible for the slow but certain evolution of superior medical schools and eradication of the diploma mills. The standardization of hospitals to higher levels of service, the critical selection of medical students with systematic training, and the creation of high standards for qualification as specialists are only a few of their accomplishments. Another milestone is voluntary hospital insurance.

The next step is *voluntary* insurance for other types of medical service with expansion based upon experience, rather than theory and imagination of an unrepresentative minority group of social reformers.

CHRONICALLY ILL (Continued)

The family has an important role in the care of the chronically ill, Dr. Kretschmer says, explaining that the patient's invalidism is too often created or increased as much by the attitude of his family and friends as by the physical condition itself. Industry too plays an important role in this problem. "Careful consideration," he states, "should be given to the aging; and effort must be made to place the older worker in a position commensurate with his capacities so that he may feel that he is taking part in production, thereby retaining his self respect. He should not be shunted off into an inconsequential position when he still is able to perform productive work. . . .

"Whether or not the chronically ill should be hospitalized in institutions dedicated to that purpose or whether they should be housed in wings built as additions to our present hospitals for acute diseases is a subject still under debate. Some believe that they should be cared for in the separate wings of the so-called acute hospitals and others believe that special hospitals should be built for that particular purpose. . . .

"Certainly for those patients for whom any significant degree of rehabilitation can be anticipated, active steps must be taken to restore independence and self reliance as fully and as rapidly as possible. . . ."

Tuberculosis can destroy the finest human material in every nation. Yet all modern knowledge shows that this disease, if fought with medical and social weapons known to us now, can be cured and largely prevented. Harley Williams, M.D., Amer. Rev. Tbc., Jan. 1945.

Medicine's Role in the War Effort

A. A. F. CLINICAL REFRESHER TRAINING

The establishment of clinical refresher training for A. A. F. Medical officers returning from overseas and for others whose assignments have provided them a minimum of clinical experience has been announced by Major General David N. W. Grant, the Air Surgeon of the Army Air Forces.

The training covers a twelve week period and consists of a two week didactic course at the A. A. F. School of Aviation Medicine, Randolph Field, Texas, and a ten week clinical course in one of the larger A. A. F. regional hospitals.

The purpose of the training, said General Grant, is to give medical officers who for a period of twelve months or more have had a minimum of active clinical work as the result of assignment to administrative, dispensary or tactical positions an opportunity (1) to study the newer methods of medical and surgical treatment and (2) to qualify for clinical positions in A. A. F. hospitals.

"It is the nature of war to prevent a great many of us from doing what we want to do," said General Grant. "Much of the flight surgeon's work is not medicine per se, yet the practice of aviation medicine is a vitally important mission requiring the scientific training and humanitarian interest of the medical officer and, with competent performance, constitutes preventive medicine of the highest order.

"The flight surgeon's success in the aero medical extension of the airman's sphere of action should be ample reward for any sacrifice of clinical interest. There have been complaints, however, that the flight surgeon does not find sufficient opportunity for enhancing his professional competence in clinical medicine and surgery. This is true. The wing, group or squadron surgeon who has been overseas for one, two or three years has had little or no opportunity for experience as a practitioner.

"A few tactical air forces which have hospital facilities as a part of their organization have been able to remedy this situation to a certain extent by rotating medical officers between field and hospital service."

For medical officers returning home, he said, clinical refresher training has been introduced in line with his long-held intent to do everything within his power to secure the futures of the men to whom he is personally as well as officially obligated for the outstanding success of the A. A. F. Medical Service.

The new postgraduate training in the A. A. F. is described as a logical sequence to the resident training provided for more than 600 young medical officers in A. A. F. hospitals accredited for this purpose by the Council on Medical Education and Hospitals of the American Medical Association.

The refresher training is given on a voluntary basis to officers for whom a hospital assignment is contemplated, preference being given to those with the longest terms of overseas service, regardless of rank.

If vacancies are not filled by returnees, medical officers assigned to administrative, dispensary or tactical positions in the zone of interior will be considered for this training.

The plan of training, as described in A. A. F. letter 50-97, dated Feb. 20, 1945, provides in the didactic phase for clinical conferences and lectures in medicine, surgery and the subspecialties, with parallel reading in textbooks and periodicals prescribed. In the second, or hospital, phase the student medical officers will perform the duties of ward officers, receive special instruction in x-ray interpretation and laboratory diagnosis and have opportunity to work in the operating room in such capacity as may be determined by the chief of surgery. All hospital training will be of an on the job character in which fullest utilization will be made of the officers' services for essential medical duties.

Facilities for training in the following specialties are available in A. A. F. hospital general medcine, cardiology, gastroenterology, dermatology, bacteriology, general surgery, anesthesiology, orthopedic surgery, otolaryngology, urology, ophthalmology, roentgenology and psychiatry.

"While the primary purpose of clinical refresher training is to prepare the medical officer for an A. A. F. hospital assignment, it is obvious that the offered course will be of postwar value to the individual," said General Grant.

ARMY INCREASES CALORIES FOR OVERSEAS COMBAT RATIONS

The War Department recently announced that more nutritive elements are being included in the C and 10 in 1 combat rations for our troops overseas. The standard ration for overseas troops, wherever they have regular access to the army kitchens, is the B ration. This ration, which already provides approximately 3,900 calories per man daily, has been found to be ample for the average soldier and remains unchanged. When troops go into combat, however, they are cut off from their mess facilities and for this reason must depend on packaged rations. The 10 in 1 ration, a packaged ration that is the next thing to the food provided by the soldier's regular mess, now provides 4,150 calories per man daily, as compared to a former caloric content of 3,927. The C ration now provides 3,700 calories, compared to the 2,775 calories. The pocket or K ration, issued for emergency use by troops, is rated at 2,860 calories and remains unchanged.

★ ★

365,437 PRISONERS OF WAR IN THE UNITED STATES

The War Department recently announced that there were 365,437 prisoners of war held within the continental limits of the United States as of April 1: 311,630 German, 50,549 Italian and 3,258 Japanese. The prisoners are being held at 141 base camps and approximately 319 branch camps located in all sections of the United States. The branch camps are designed to place prisoners near current work projects. About 35,000 of the Italian prisoners of war were members of Italian service units directly engaged in war work. They contributed almost a million man days of work to the war effort during the month of March. Of the remaining war prisoners, an average of more than 43,000 were working on contract labor and more than 150,000 were working at Army, Navy and Air Corps posts, camps and stations. Additional prisoners were assigned to "housekeeping" duties within their own prisoner of war compounds, and the remainder of those not working were either hospitalized or officers of nonworking noncommissioned officers who cannot be forced to work under terms of the Geneva Convention.

Prisoners working on posts, camps and stations during March were employed principally in the laundries, in clothing and equipment, in warehouses, in quartermaster shops, in the maintenance of buildings, utilities, grounds and roads, in motor maintenance and repair and in bakeries and messes of American officers and enlisted men.

★ ★

LET'S WALK

Under the title "Let's Walk," the Convalescent Training Division of the Office of the Air Surgeon has issued a manual (Air Forces Manual No. 49) which is designed to teach the man who has had a leg amputation to walk again. It is a well illustrated, carefully prepared handbook, telling the man how to exercise in order to prepare his muscles for the job. There follows a history of crutches, with a description of the various types available and full information leading up to the ultimate use of an artificial limb. The book is based on a large experience and should be most helpful in achieving its purpose.

★ ★

EDUCATIONAL OPPORTUNITIES FOR ARMY DOCTORS

Since the start of World War II, over 6,000 selected medical officers have been graduated from short but intensive courses given by the Medical Department in some thirty critical medical and surgical specialties, according to Major General George F. Lull, Deputy Surgeon General. In addition, refresher courses in general medicine and surgery provide medical officers with a chance to "brush up" before returning to professional assignments after other duty.

Many doctors also benefit while in service from working under key professional personnel in military hospitals. Other medical officers who have been on duty with combat troops in the field are given an opportunity to brush up on their specialty through the rotation policy.

General Lull reported that 350 doctors have been reassigned from field to hospital duty during the past year in the Mediterranean Theater and "the merit of intra-theater rotational plans has been pointed out to other theaters, and is being encouraged in order that the maximum number of doctors might receive refresher training while they are still in military service."

Naturally, professional training of medical corps officers during military service must be restricted to meet military rather than civilian requirements. However, General Lull said, The Surgeon General is keenly interested in the welfare of these doctors and will provide "insofar as is possible" opportunities for professional training.

In the post war period, he added, all doctors will be entitled to professional training, after their release from service, under the G. I. Bill of Rights, and those who remain in the Army will have the opportunity for refresher training at selected military hospitals and civilian schools.

★ ★

EXPENDABLE REFRIGERATORS PROLONG LIFE OF WHOLE BLOOD

Whole blood, flown from this country to the European Theater of Operations, keeps in condition for transfusions 5 days longer than formerly, or as long as 21 days, because of a new system of refrigeration inaugurated this month, according to the Office of The Surgeon General.

The bottled blood is now being flown overseas daily in compact, expendable ice-boxes made of metal foil on cotton insulating board which keep the blood within safe temperatures: between 39 and 50 degrees fahrenheit. The containers, measuring 21 x 21 x 25 inches, weigh only 105 pounds when carrying their full capacity of 24 bottles. Each bottle contains about a pint and a half of whole "O"-type blood.

An elaborate system has been set up overseas to complete delivery. The blood is flown to focal points in

all forward areas. Blood bank detachments at those points service all Communications Zone medical installations in the area and truck the blood farther forward to advance detachments which deliver it to the operating surgeons.

Brigadier General Fred W. Rankin, USA, Director of the Surgical Consultants Division, Office of The Surgeon General, stated that whole blood plays such a vital role in the saving of lives that anything extending its use is of prime importance.

★ ★

MAJ. H. A. LOWY SERVES IN CHINESE THEATRE OF WAR

Promotion of Howard A. Lowy, 31, son of Mr. and Mrs. George J. Coffey of 5232 W. 23rd St., Cicero, Ill., from captain to major, has been announced by Major General R. B. McClure, commanding general of the Chinese Combat Command.

Lowy, who is serving as assistant to the surgeon at a headquarters of the Chinese Combat Command near Kunming, was graduated from St. Ignatius High School, Chicago, in 1931, and received his Ph.C. degree from the University of Illinois College of Pharmacy in 1934 and his B.S. and M.D. degrees from the University of Illinois College of Medicine in 1939.

He was engaged in the private practice of medicine at Creve Coeur, Illinois, prior to his entry into the Army in October, 1942.

He arrived in India in September, 1943, where he served as medical officer of the India-China Wing of the Army Transport Corps. In June, 1944, he was flown across the Himalayan "Hump" to join the American military mission, which trained, supplied and equipped the Chinese Expeditionary Force in its successful Salween compaign, the offensive which drove the Japs from southwestern Yunnan Province, thereby making possible opening of the new Stilwell Road.

The major is holder of the Presidential Unit Citation awarded for his service with the India-China Wing of the Army Transport Corps, and is also entitled to wear two bronze stars on his Asiatic Pacific Campaign ribbon — one for service in India and the other for service in China.

★ ★

FAVORABLE REPORTS ON TRENCH FOOT

Reports from the Army general hospitals at Camp Butner, N. C., and Camp Carson, Colo., which are trench foot treatment centers, indicate that the cases now under treatment are for the most part mild. Lieutenant Colonel Roy H. Turner, MC, Acting Director, Medical Consultants Division, Office of The Surgeon General, who recently returned from an inspection trip, stated that, with the exception of a very small percentage of cases, evidence of injury to the feet is slight and recovery is both rapid and exceedingly satisfactory.

The mildness of trench foot cases now being hospitalized is largely due in the opinion of Colonel Turner, to the Army's intensified education of troops concerning trench foot which has resulted in the prompt reporting of cases, early diagnosis, and immediate treatment.

LST HOSPITAL SHIPS SAVED LIVES AT IWO JIMA

Four of the big LSTs at the invasion of Iwo Jima were transformed into floating medical evacuation stations within a few minutes after their amphibious tanks were launched. Remaining close inshore throughout the operation, wounded men were on their operating tables in some instances within twenty minutes after they had been hit. The four ships had been so loaded that all of their tanks would hit the water within seconds after their arrival on the line of departure. These tanks were for the first wave. Navy Medical Corps personnel rode to the operation aboard the "hospital LSTs." Operating tables set up in the troop quarters long before the island was sighted were soon ready. As the last "water buffalo" rolled down the ramp, cleaning crews went to work and before the first wave had reached shore the huge tank decks had been transformed into 150 bed hospital wards. The work of the doctors on the four ships was under the direction of Capt. Robert M. Gillette, formerly of Altadena, Calif.

★ ★

MEDICAL-SURGICAL CONFERENCE AT 300TH GENERAL HOSPITAL

Probably the largest military medical meeting ever held over-seas was sponsored by the 300th General Hospital January 26-27 at the hospital in Italy. More than 600 officers attended, drawn from all over the Mediterranean Theater of Operations. The General Sessions, which were presided over by Col. George W. Reyer, commanding officer of the 300th General Hospital, were featured by addresses by Major Gen. Morrison C. Stayer, surgeon Mediterranean Theater of Operations; Brig. Gen. Joseph I. Martin, surgeon Fifth Army; Col. Frank Berry, surgical consultant Seventh Army; Col. Perrin Long, medical consultant Mediterranean Theater of Operations, and Lieut. Col. Tracy B. Mallory of the 15th Medical General Laboratory. The scientific sessions were divided into a medical and a surgical section, and each of these had programs running simultaneously composed of papers, lantern slide lectures, clinical demonstrations, ward rounds and reports of cases.

The private physician determines the presence or absence of tuberculosis. He has the responsibility, not only of making a diagnosis and advising treatment when indicated, but also of convincing the patient to accept his advice. The physician should be meticulously careful that in an effort to spare the feelings of the patient he does not minimize the importance of the disease, both to the individual and to his family and other associates. The patient should realize that he has tuberculosis and not a "shadow" or "spot" on his X-ray film, that continued observation is absolutely essential, and that if treatment is indicated it is imperative that he accept it. Roberts Davies, M.D., Nopeming San., Nopeming, Minn.

Original Articles

OCCUPATIONAL DERMATOSES (DIAGNOSIS — MANAGEMENT — PREVENTION)

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The occurrence of dermatoses in industry has been of decided importance for years because of their many resulting disabling factors and consequent loss of man power. In times like this, when loss means a distinct slow-up, our attention is more than ever attracted to their importance, especially those in the war industries. The rapid expansion of our industrial program which involved the conversion of peace-time factories into ordnance and munition plants and the employment of large numbers of people in hazardous occupations before modern safety appliances can be installed and before new workers can be educated as to the health hazards of their new jobs, necessarily results in an increase of occupational diseases.

The skin, being the portion of the body which comes in contact with external irritants, is the first to be affected by many of these industrial poisons. In fact, Dr. Louis Schwartz, medical director of the Dermatoses Investigation Section of the U. S. P. H. S., states that most of the occupational diseases encountered in these new war industries are dermatoses.

As to terminology, many have been used. Dr. C. Guy Lane feels the term "dermatosis industrialis" should include all the eruptions having occupational origin. This term he would qualify by the type of skin lesion produced and the name of the causative agent; if this last is unknown, he would substitute the occupation. We ordinarily think of dermatitis venenata being an eruption of severe manifestations as edema and large bullae, while an occupational dermatosis is usually a localized dermatitis venenata and we think of more of an eczematoid eruption and having chronic rather than acute characteristics. Again, in occupational dermatoses we have the inhalant factor, in which the eruption appears as an internal absorption. The term industrial dermatitis is probably as correct and as comprehensive as any other designation. If produced entirely by contact, one might say a contact dermatitis.

It is necessary not only to detect that a dermatitis is actually of occupational origin but it is essential to render the appropriate treatment to cure the patient as fast as possible. To accurately as possible detect the etiologic agent will prevent a recurrent in that patient, and, in general, institute preventive measures to prevent occurence in others. In order to investigate intelligently the cause of industrial dermatoses, Schwartz points out that one must have at least a sufficient knowledge of dermatology to distinguish a contact or occupational dermatitis from such ordinary skin diseases as psoriasis, impetigo contagiosa, urticaria, pityriasis rosea, lichen planus, acne vulgaris, and superficial fungus infections, as ringworm.

While most irritants in industry produce an eczematoid reaction suggestive of a dermatitis venenata, there are other skin manifestations which are not expressed in this way. It must be recalled that there is loss of pigment of the skin

From the Department of Dermatology, Loyola University School of Medicine.

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such as occupational vitiligo, as shown originally by E. A. Oliver. Then there are the hyperpigmentations, as the melanoses, as described in detail by Harry Foerster. There are also the follicular reactions due to the oils. Another follicular expression is that of so-called chloracne occurring in people who are in contact with the chlorinated hydrocarbons. Among infections of occupational origin are the erysipeloid of Rosenbach which has been forcibly brought to our attention by Klauder; furunculosis or boils occurring in epidemics, fungus infections of the animal type occurring in workers in hides, and deep fungus infections in nursery employees, as sporotrichosis.

Other Special Diagnostic Findings. — A discoloration of the skin occurs in workers in lacquer, painters and dyers, workers in saltpeter, and in sulphuric acid. Skin deposits are associated with industries like handling wool, flour, cement and lime. Fissures of the fingers and fingertips are seen in dressmakers and basket makers. People working in the presence of disseminating heat develop a pigmentation of a retiform distribution, so-called livedo calorica. The development of argyria in workers who apply silver coatings to glass beads, etc., is well known, the silver entering the epidermis and reaching the cutis through the blood stream. Calluses and cornified areas form for protection against various sorts of local irritations. Tattooing occurs in workers in stone, gun powder, iron and steel. Tissue burns of varying degrees occur as industrial injuries in metal workers and these are well known and handled best by the industrial surgeon rather than the dermatologist. Acid and alkali burnings play a large role in industrial injuries. The halogen salts, especially iodine and bromides, produce an acneform eruption, particularly in the areas of ordinary acne. Follicular papules, resembling acne, are well known in workers of oil and tar. Consequently, people who handle petroleum and its derivatives are especially liable to present acne-like diseases, as before mentioned.

Inorganic Agents. — Many inorganic substances will cause injury to the skin. Workers in wallpaper and enamel may have a scarlatiniform eruption and even vesicular oozing dermatoses from absorption of arsenic. After prolonged contact, the well known warty arsenical beratoses may develop on the palms. These can develop into squamous cell carcinoma. Oftentimes similar eruptions are caused by antimony and its derivatives in workers in rubber and artificial silk. Sensitivity to nickel, as in nickel sulphate, and chromium compounds as used in the graphic industries, may cause sensitization dermatoses. These may also cause localized tissue destruction, the chrome ulcers being a noted example. In hypersensitive patients cobalt may cause edema of the hands with the formation of vesicles. Petroleum, tar, benzene, formaldehyde, produce both allergic and toxic eruptions. Anilin, used by painters, dyers, etc., is apt to cause edematous and oozing eruptions. Turpentine may give rise to weeping and oozing dermatoses of allergic character. In bakers and millers potassium and ammonium persulphate produce a sensitization dermatosis. Hypersensitivity to various woods and bark and various trees produces another class of occupation or trade dermatoses. Several cases have been seen due to contact with fruits and vegetables, e.g., asparagus, carrots, tomatoes and oranges.

Diagnostic Criteria. — There are a number of criteria that make for accurate diagnosis, because many times it is thought by patients that any eruption which appears while a person is working is of occupational nature. The history of events is very important. This should bring out the fact that the dermatitis was not present before the patient entered on his present occupation, that it developed during a period of industrial exposure or after a lapse of a reasonable period after the stoppage of the exposure. The site of eruption is important. The eruption must have begun first on the exposed parts, i.e., on the hands, fingers or forearms if the offending material is a solid or liquid. If the offending material is a vapor, it is more apt to be on the face and neck. In cases of irritant dust which may pentrate the clothing, the covered parts of the body may be affected first, especially if the clothing is not changed frequently. In some cases, the points of friction, such as the wrist where the gloves and sleeves rub or the belt line where the belt or trousers cause friction, may be the first affected.

The appearance of the lesions is usually quite characteristic. An acute industrial dermatitis begins as an erythema followed by papules, vesicles, oozing and crusts, no matter what the irri-

tant may be. There are a few classes of industrial irritants which present more or less characteristic lesions on various parts of the body, such as a paronychia common to fruit and vegetable handlers. Acneform lesions caused by the chlorinated waxes, coal tar and petroleum oils. Folliculitis is very often caused by oil and boils by oil and soiled clothes. Keratotic and malignant growths are caused by coal tar and certain petroleums and arsenic, as before mentioned.

As a confirmatory measure to detect certain irritants, patch tests are performed. A patch test consists of applying a small amount of the suspected irritant in the strength in which the patient encountered it in his work. Obviously, one cannot use a primary irritant in that it would not only lead to a wrong conclusion but if material is used in full strength, it could cause a serious necrosis with its medicolegal sequelae.

The actual differential diagnosis is, at times, somewhat difficult, but a rule that applies in many instances is that a dermatitis due to occupation tends to get well when the patient is removed from the work and recurs after he goes back to his same job.

Oil Dermatoses. — In taking up some of the actual dermatoses, those of the war industries will be first briefly described. The teachings and findings of Dr. Louis Schwartz will be very freely quoted. One of the very frequent causes of dermatitis in the factories engaged in the production of war material is the cutting oils. As these oils are used in the making and machining of metal parts, they are used a great deal in the manufacture of almost everything connected with the war, especially tanks, guns, small arms, projectors, trucks and airplanes, etc. The cutting oils are divided into two large groups, the soluble and insoluble. The soluble oils in general consist of sulfonated mineral oils, soap, resins and sulfonic acids. Some preservatives are added, for instance, phenol. The soluble oils are usually mixed with water in various proportions and flow continuously over the cutting operations, thus cooling the cutting tools as well as furnishing some lubrication. The insoluble oils consist chiefly of mineral oil, some fatty oil, a small per cent of sulfur and chlorine. All petrolatum oils de-fat the skin. Then, of course, the type of skin has a marked effect on this sensitivity, a dry skin being especially susceptible. Cutting oils after being used contain many steel slivers which may wound the skin of the workers, especially if old dirty towels or old waste material full of slivers are used to cleanse the hands.

Cutting oils produce many kinds of dermatitis but usually folliculitis. This folliculitis is definitely due to the oil irritating the follicles and the U.S.P.H.S. has found that the staphylococci and streptococci are usually of very little influence. Allergic dermatitis is the least frequent type caused by cutting oil. Occasionally there is a hypersensitivity to the oils, the inhibitor or the disinfectant in the oil. In such cases, there will be a positive reaction to the patch test with the cutting oil used.

Explosives. — So far as experience among explosives is concerned, tetryl is the chief cause of dermatitis. It affects new workers from one to two weeks after they begin handling it. Ten to fifteen per cent of all new workers are affected. The dry powdered tetryl causes a larger percentage of dermatitis than do the pellets or the wet tetryl. Tetryl dermatitis usually begins on the face because the tetryl-soiled fingers are unconsciously applied to it. Points of friction, such as the collar line and the wrists, are favorite sites for dermatitis. The face often becomes so severely affected that the eyelids are closed and the lips are swollen. The hands and faces of workers coming in contact with tetryl are often discolored to a yellowish-brown color, similar to that imparted by picric acid. The hair of many of the workers is dyed a reddish-yellow color.

In taking up the eczematoid lesions, three important factors present themselves at once. First, is it dermatitis venenata due to articles handled in the patient's work or at home? Second, is it an infectious dermatosis, especially of the ringworm group? Third, is it an eruption due to sensitization due to ingestant, especially of food? These three main headings constitute the three cardinal things to consider.

Skin hazards present in certain American industries have been studied in detail by the U.S. P.H.S., e.g. oil refining, rubber industry, candy making, leather manufacturing, fur industry, artificial silk, citrous fruit, paints and varnishes, pulp and paper, explosives, etc. Naturally, there are numerous features peculiar to the various industries.

There has not been as much attention paid to the prevention of occupational dermatitis as to the prevention of occupational poisonings, de-

spite the fact that there is more time lost from work on account of occupational dermatitis than from any other occupational disease. Unlike the protective measures against systemic occupational diseases which are practically the same for nearly all, namely, reduction of the concentration of the poison in the air by enclosed processes and exhaust systems, the same method of prevention will not suffice against the various skin irritants encountered in our industries. There are many protective measures against the different sources of industrial skin irritants.

The protective measures should begin in the preemployment examination where the skin of the applicant should be carefully examined and any pathologic conditions noted. Applicants with skin eruptions should not be employed in occupations where there is a marked skin hazard; for instance, those applicants having allergic eczemas should not be employed where there is a marked skin hazard from such well-known sensitizing chemicals as tetryl, fulminate of mercury, the picrates, TNT, formaldehyde and its compounds, synthetic dye manufacture, and others.

Preemployment patch testing for the purpose of discovering those workers who are allergic is not advisable because workers are usually not allergic to chemicals with which they have had no previous contact. Therefore, very few, if any, would be discovered by this method. Patch testing workers with sensitizing materials may be the means of sensitizing them. Careful note should be made of the sites of acneform lesions on applicants for work in occupations where they are to be exposed to such occupational acne producers as the solid chloro-hydrocarbons, cutting oils, heavy coal tar distillates, crude petroleum and lubricants derived from it.

The presence of active ringworm infections on the feet and other parts of the body should be noted. If the applicants are otherwise employable, the fungus infections should be treated while they are working, and the parts affected should be properly protected from the action of occupational irritants. If there are common shower-baths in the factory, care should be taken to prevent the spread of fungus infections of the feet. The workers should also be instructed that they should thoroughly dry and spread powder between the toes before putting on their stockings. The fungi do not grow in dry media. There are many powders on the market for this purpose, and most of them contain some antiseptic, such as oxygen in the form of perborates and peroxides, and other fungicidal chemicals.

Applicants who have dry skins should not be placed at any position where they must immerse their hands in fluids which defat the skin such as strong soaps, alkaline solutions or the volatile solvents.

Properly designed protective clothing is of great value in the prevention of occupational dermatitis. Closely woven cotton fabrics that are more or less impervious to dust are frequently used to protect workers from such irritant dusts as sodium carbonate, calcium cyanamide, etc. For such fabrics to give efficient protection, they must be frequently cleaned.

Impervious materials, such as rubber, offer better protection against dusts than do fabrics, and they also give protection against irritant liquids. Rubber gloves, aprons, boots, and sleeves are impervious to water-soluble irritants. Rubber, however, soon deteriorates when exposed to alkalis, petroleum distillates or the chlorohydrocarbon solvents.

Leather gloves offer good protection against trauma and irritant or sensitizing solids and dusts. Leather gloves should be made of soft, pliable, washable leather, such as chamois. The seams should be finished and smooth. Coarse seams rub and irritate the skin, causing dermatitis by mechanical friction. Gloves for the protection of the hands from irritant chemicals should reach well up the forearms and should be worn under impervious sleeves, fastening at the wrists so as to prevent the entrance of irritant chemicals into the gloves. Aprons should reach well up to the neck and below the knees. Aprons are of a special value in protecting the body from cutting oils. One must again emphasize the fact that, in order for protective clothing to be really protective, it must be kept clean.

Cleanliness. — Cleanliness is by far the most important single measure for the prevention of industrial dermatoses. By cleanliness, we mean not only cleanliness of a person, but cleanliness of the room, the machines and the clothes. Floors, walls and ceilings of rooms in which there are industrial irritants should be wet-cleaned daily. Machines and tools on which industrial irritants deposit should also be cleaned daily. Adequate washing facilities should be

provided for workers handling industrial skin irritants. Workers whose clothes become soiled with industrial skin irritants should be compelled to take supervised shower baths after work, before leaving the factory. It may be necessary to have a double set of locker rooms to be sure that the workers do not put on dirty clothes before going home. Care must be exercised so that the soaps and other cleansers used by workers to remove dirt, dyes, oils, etc., will not themselves cause dermatitis. Workers who become soiled with oils, greases and dyes are likely, if left to themselves, to use the most available and most rapid acting solvent to clean the skin. They do not stop to consider the irritant action of the cleanser. Many cases of dermatitis among workers have been caused by the cleansers used before going home. Then it should be seen that the workers use only such cleansers as will not act as skin irritants.

The cleanliness factor, as for as personal hygiene is concerned, has been greatly exaggerated in the causation of industrial dermatoses especially oil folliculitis. Recent research work has shown that people who are considered clean (in fact, professional people) and who had never worked in oil, developed an oil folliculitis when oil was placed for 24 hours on the wrist, beginning six to eight days' time and persisting for ten days to two weeks with only one application. Cleanliness in avoiding oil is desirable of course, but who can avoid oil when he needs to work in it?

An industrial cleanser, according to Dr. Schwartz, for the normal skin should theoretically have the following qualities:

1. It should be freely soluble in hard, soft, cold, or hot water;
2. It should remove foreign soil, fats and oils without harming the skin.
3. It should not contain harsh abrasives or irritant scrubbers.
4. It should be handy to use in cake form, or should flow easily through soap dispensers if in granulated powder or liquid form.
5. It should not deteriorate or become insect infested.

For those occupations in which excessive scrubbing with such soap is necessary in order to remove dyes or tenacious oil, it may be better to add to such a cleanser a small amount of alkali, such as trisodium phosphate, or an organic solvent, such as naphtha. Whenever such alkali reinforced cleansers are used, it is best to supply the worker with an emollient cream to be rubbed into the skin after washing so as to replace the fat removed by the strong cleanser.

Those workers who have dermatitis, sensitive or dry defatted skins, should not use the ordinary industrial cleanser previously described. It is better for them to use one of the soapless cleansers, the pH of which is 7 or less. Such a cleanser may consist of a neutral sulfonated caster oil containing from 1 to 2 per cent of the synthetic agents.

Protective Ointments. — While protective ointments are low on the list of preventive measures, they are often the only available means of protection. In most occupations, the face cannot be covered by protective clothing. The work must often be performed with bare hands, the gloves being unsuited for the operation. Workers, as a rule dislike to wear protective ointments. When a protective ointment is used, the worker invariably washes it off with soap and water immediately after work and so removes not only the ointment but whatever irritants there are on the skin. This *washing after work* adds considerably to the value of the protection *supposedly* given by the ointment. There is no one formula for a protective ointment which will give sufficient protection against all skin irritants.

SUMMARY

Clinical features of various common types of occupational dermatoses and cutaneous syndromes are described.

The various etiological agents are enumerated.

Protective measures are briefly discussed.

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Poverty or the fear of poverty, more than any single factor, changes the tides of battle in favor of the tubercle bacillus in the individual or in the family. Poverty engenders crowding, ignorance, nutritional deficiencies, and medical neglect; all of which create a favorable soil for the tubercle bacillus. The result is that benign infections become malignant, closed or sputum negative cases become open or sputum positive cases, the spread of germs becomes constant and massive, and cases multiply. Robert E. Plunkett, M.D., Conn. State Med. Jour., Jan. 1944.

RECENT TRENDS IN RADIATION THERAPY OF CANCER

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When x-rays were first discovered by Conrad Roentgen fifty years ago they were called x-rays, the x indicating the mathematical symbol for the unknown. To-day, even though the name x-rays still persist very much is known about them both as to their physical qualities and biological effects on normal and pathological tissue and are now more properly named after their discoverer and called Roentgen rays. The mysticism and mysteriousness concerning them is disappearing with ever increasing knowledge and in the use of radiation — radium and x-rays, certain trends have been developed. These trends represent certain lines of thought and many points of view. Many ideas and convictions concerning their proper use for the different types and kinds of cancer may differ widely and there may be and are many hot arguments regarding the best procedure in any given condition. While there are many honest differences of opinion, in looking back over twenty-five years in this field and looking forward to the future, these trends are quite clearly defined. This paper is in the nature of a resume and preview.

Time Factor. — Up until about the year 1920 practically all radiation therapy was given at the voltage ordinarily used for radiography, i.e. fifty to one hundred thousand volts. With the introduction of larger transformers and better tubes, the so-called "deep therapy" was introduced.

The largest impetus to x-ray therapy at these higher voltages (in this field now classified as "deep-x-ray") was made by the Germans during and shortly after the first World War. They introduced the "massive dose" technic. By this plan a patient with a deep-seated carcinoma received his full quota of treatment all at once. The period of administration frequently lasted as long as eight to ten hours. The results in some instances were startling but in many other instances disastrous. Because of the many radiation accidents following this plan, fractionation of the dosage was resorted to. Instead of giving the whole treatment in one massive dose in one day, numerous smaller amounts were given over a prolonged period of time. This was done very largely to avoid the serious roentgen sickness but the idea of fractionation had been stimulated greatly by Regaud who found that by breaking up the dose over a number of days he could produce effects upon the germinal cells of testes of the rabbit that were lethal in character without serious damage to the overlying skin, while if this amount of radiation had been administered all at once serious skin necrosis would have resulted. This led to the discovery of the fact that cells, both normal and pathological, are much more susceptible to radiation effects during the period of mitosis than in their resting stage and that by fractionating and prolonging the period of time of administration of the radiation over a number of days many more cells could be caught during their period of mitosis. This was indeed a most important and basic discovery.

In spite of the fact that most cases of carcinoma to-day are treated by the fractionated method the massive dose technic is still followed at least in part in many hospitals and clinics particularly in the treatment of carcinoma of the lip. Why carcinoma of the lip should be an exception I cannot understand unless it be because it is superficial. Carcinoma of the lip, one of the most curable lesions by radiation, is deserving of as much consideration and care as any of the deep-seated lesions. While the massive dose applied all at once cures many, there are, I am convinced more recurrences than following treatment by the fractionated method, particularly with filtered radiation as contrasted to unfiltered and especially when a large field is used rather than a small one. Many dermatologists treat a small field over the local lesion alone with a massive dose of unfiltered radiation that does not reach the depth of the lesion and there are many recurrences after treatment by this method; with a large field taking in the whole of the lower lip with filtered radiation and fractionated dosage there should be practically no recurrences, that is if the lesion is localized and confined to the lip.

Filtration. — Another important factor in

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radiation therapy in which there has been a definite trend is from little or no filtration to an ever increasing amount of filtration. It has long been known that with higher voltage, greater filtration, and greater distance, better depth doses are obtained together with a more homogeneous distribution of the rays. From a strictly physical and economical standpoint with the so-called "high voltage" or deep therapy technic at 200 KVP. a filter greater than 0.5 m.m. cu. may not be needed but during the past five to ten years many of the radiological institutes and radiologists in this country have found that they could get better results with a filter equivalent of 2 m.m. cu. Skin changes were also markedly reduced. Considerable earlier investigation has failed to demonstrate that the shorter wave length of even the gamma rays of radium (equivalent to one million volts or more, as compared with the roentgen rays used in clinical practice 100,000 to 200,000 volts) produced any differences in biological effect on living cells. It is believed that equal quantities of radiation energy whether of gamma rays or roentgen ray sources produces quantitatively equal and qualitatively equal biological effects. However, to effect a cell, radiation must reach the cell; the action of radiation is direct and local in scope. While this above statement has been the generally accepted point of view, since the introduction of the so-called super voltage, x-rays, that is x-rays generated from 300,000 to a million volts, there is a trend away from this concept and a number of authorities such as Failla, Woods, and others have come to believe that there is after all a specific wave length effect. Whether or not this is true, in order to achieve a cure, every single cancer cell must be destroyed and if there is even no greater effect on cancer cells by the shorter wave lengths, it is clearly demonstrable that there is less effect upon the normal tissues and overlying structures are spared. Therefore, the differential between normal and cancer tissues is increased and it is possible to give larger doses to the cancer without irreparable damage to the surrounding normal tissues and organs especially the skin. This can be clearly demonstrated clinically even though it may not as yet be capable of experimental proof. Herein, lies the matter of successful treatment—the proper selection of wave length (or in other words voltage and filter) and the proper time factor.

Large Fields Vs. Small Fields. — Which should be used, a large field in order to include all of the tumor and its ramifications or a small field to spare as much of the surrounding normal tissues as possible? In the use of the small field, particularly if the tumor is deep-seated, the beam of x-rays can miss the tumor if even only slightly misdirected. This was clearly demonstrated by Lauritzen at the California Institute of Technology with his double chamber iometer, one chamber on the skin and the other chamber in the vagina. With a slight movement on the part of the patient the tumor may get partially or entirely out of the field. The amount of backscatter of rays produced with the smaller field in contrast to the larger field, is markedly reduced. These are the arguments against the use of the smaller field.

There are, of course, many advantages in the use of the small fields. With the small fields the amount of effect on normal tissues is markedly reduced; the lesion itself is treated without taking in any additional territory. In cavities such as the mouth or vagina the small cone has been a great advantage.

In my hands, at least, the objections to the small field, outweigh its advantages. With a larger field the tendency for the tumor to get out of the treated area is reduced to a minimum. Movements of the patient are not so serious and the increased backscatter effect in the tissues is a decided advantage. In the use of the smaller field particularly with the Odman cone with a field diameter of less than 5 cm. it is almost impossible to keep the patient quiet and keep the lesion in the treatment field, especially old people and children.

While there is a trend more recently toward multiple small fields it has not been my policy to follow this trend. I do not trust small fields.

Radiation Sensitivity and Radiation Curability. — Radiation sensitivity as contrasted to radiation resistance was one of the earliest biological phenomena to be noted when radiation therapy was introduced early in this century. The law of Bergonie and Tribondau, that is, "the less differentiated the cell, the greater its sensitivity" may have been elaborated upon and extended but this basic concept has never been

changed or improved upon. However, with the advancement of our knowledge of radiation effects, with the improvements made in x-ray apparatus, particularly the production of larger quantities of short wave-length x-rays (again greater filtration and higher voltage) many tumors formerly considered as radiation resistant are now considered as curable. In my experience, such tumors as adeno-carcinoma and osteogenic sarcoma which were formerly considered incurable have in many instances responded favorably to such radiation therapy. It still remains true that radiation sensitivity does not by any means mean curability because it is notoriously true that the more rapidly growing undifferentiated cells are much more rapid in their extension either by lymph channels or blood stream and while the local lesion may respond remarkably to a comparatively small dosage, due to the rapid spread of the disease, the results of treatment are only temporary. From the standpoint of the patient, a schirrus type of carcinoma of the breast may offer a better outlook than the meduallary type. Take, for example, lymphsarcoma. The reason for its radiation sensitivity is undoubtedly the rapid cell growth; this is also the basis of the more rapid extension and metastases and even though more cells are caught in their dividing and susceptible stage than in the resting stage, still the condition may and usually does prove fatal. Radiation sensitivity and curability are by no means synonymous.

Palliation. — There is no question but that many apparently hopeless cancers can be cured but it also remains true that the more advanced a carcinoma is the less chance there is for a cure. In the apparently hopeless case of carcinoma the radiologist should not be overambitious and subject the patient to the distress, discomfort and frequently the pain caused by severe radiation reactions when all that he can reasonably expect to accomplish is relief of symptoms. On the other hand, the radiologist should not be satisfied with simple palliation because he thinks the case is an advanced one and there is no chance for cure. This is a matter for careful judgment and fine discrimination. More patients are harmed by undertreatment than by overtreatment and the radiologist can very frequently salve his conscience by saying to himself "Oh, well, she was incurable anyway." This may justify his lack of courage but in no field of medicine or surgery is it more important "to know you are right and then go ahead." It may be said that in order to produce a cure a tumor must receive a dosage of three to five thousand roentgen units on the tumor—not the skin. As to whether a case is one for mere palliation or whether a cure is to be attempted must be determined by the radiation therapist and unless he is willing to take the responsibility of giving adequate treatment he is failing to do his duty. The present day trend in the better clinics and hospitals that are equipped with modern apparatus and manned by trained radiologists that are familiar with proper dosage measurements is to consider a patient as having some chance for a cure in almost every instance. In view of the fact that suits for malpractice are no longer the bugbear of the radiologist who is trying to give adequate treatment there is less excuse than ever for inadequate treatment. The physician and patient to-day accept the discomfort and distress and hazard of surgical procedure and they must be made to realize and appreciate the necessity for certain degrees of mutilation and discomfort and hazards with radiation. Both physicians and patients must realize that marked reactions in mucus membranes and skin are necessary if cells are to be killed.

Radiation treatment in cancer is a procedure that should not be undertaken lightly. Radium and x-ray are capable of great harm as well as good and tragic results in unskilled hands are common. The mere possession of x-ray apparatus or facilities for owning or renting radium does not make a radiologist any more than surgical ability is determined by the ownership of surgical instruments.

Radium Or X-Ray, Which? — The question frequently arises what should be used, x-ray or radium? In many instances either agent can be used with equally good results. Frequently one or the other agent is preferable because of the size and location, distribution or thickness of the lesion. In general it may be said that radium applied topically or interstitially is valuable in small superficial lesions. X-ray is preferable in large deep-seated lesions. However, in a great

many instances a combination of the two will produce the best results.

Such an instance is one of the most important conditions treated by radiation therapy, carcinoma of the uterine cervix. In this connection let me quote Louis C. Scheppey, Professor of Gynecology, Jefferson Medical College reporting in 1943 on 285 cases treated in the Gynecological Ward at Jefferson Medical College. He says "Of more interest is the manner of employment of irradiation therapy and the results achieved thereby. From 1921 to 1931 radium was used principally, most often as a single primary application. External irradiation with the x-ray was employed more or less sporadically during this time—subsequent to the local use of radium—and most often in instances of recurrences. From 1931 to 1934 roentgen irradiation was used much more frequently and systematically, subsequent to the radium applications, and as a regular plan of therapy. During this time, too, the x-rays were used more widely in far advanced cases. In 1934 and 1935 external irradiation first began to be used regularly as a preliminary procedure. Since 1936 preliminary external x-ray irradiation has been instituted as a routine procedure of choice and this plan is in vogue at the present time. ***** There is no doubt that the x-rays diminish local necrosis, slough and infection; pain and bleeding are frequently relieved as well."

To be effective radiation therapy must be carried out intensively at the first attempt. Repeated incomplete treatments seldom control the disease and *both* radium and x-rays must be used thoroughly and efficiently—radium alone cannot be depended upon, because the penetration of the gamma rays into depth are inadequate. The local application of radium in every instance must be supplmented by a full and thorough course of external radiation with x-ray. To do less is not giving the patient an even break in this most serious and too frequently fatal disease.

Supervoltage. — Much already has been said in this paper showing the trend during the past twenty years toward higher filtration, higher voltage and greater penetration. In the present state of our knowledge there is no reason to alter our concept of the modus operandi of the Roentgen and Gama rays. It is an ionization effect upon the living cells causing damage and if enough is administered causing death; with more penetration, the cells of deep-seated lesions can be reached with a minimum of damage to overlying tissues. It is obvious that a tumor 10 cm. below the surface should not be treated by irradiation which will be entirely or largely absorbed in the first 5 cm. of tissue, a greater filtration and voltage is needed—shorter wave lengths of greater penetration. These conditions of greater penetration may be met by increased filter and increasing the distance but at the expense of time. I say these conditions may be met but usually they are not due to economic and mechanical factors governing the conduct of the average busy radiological department. Who can spend one to two hours a day on a patient? However, these conditions are, in most instances, easily complied with, by adequately increasing the voltage into the range above 200,000 volts, that is 300,000 to 700,000 volts, the so-called supervoltage range. By getting into the range of these higher voltages, more filtration, greater penetration, shorter wave length, greater distance, many more cases are brought into the range of curability or at least increased palliation. Let me cite one such instance, bronchial carcinoma as reported by George W. Holmes in October 1942.

"The use of radium has been discontinued in the author's clinic in the treatment of carcinoma of the bronchus. It is possible with supervoltage roentgen rays to cause a complete disappearance of the primary tumor in selected cases without serious injury to the surrounding tissues. Rather large doses, up to 5,000 to 6,000 r. given through a small field carefully centered over the primary tumor, will often relieve the bronchial obstruction and establish drainage. In no case is it justifiable to give heavy irradiation to large areas of infected lung tissues. Malignant adenomata and epidermoid carcinoma are radioresistant, but palliative results have been obtained. Treatment by irradiation gives the best palliative results in the "oat-cell" and other highly malignant tumors, and at the present time should be the method of choice. In large radiosensitive tumors the daily dose, especially in the early stage of this treatment, should not be too great.

If a primary neoplasm is discovered early,

and there is a reasonable chance of a cure, the author believes that surgery offers the best possibility of a five-year survival."

It is now two years since I installed my 400,000 volt machine and I can definitely state that in deep-seated lesions such as carcinoma of the cervix, rectum and bladder and in resistant lesions such as osteogenic sarcoma, better results in my hands at least are being achieved than previously obtained with the ordinary "deep x-ray therapy" at 200,000 volts.

DISCUSSION

Dr. E. G. C. Williams (Danville): I came up today particularly because of Dr. Pettit's paper. Knowing him to be a very astute student of the cancer treatment problems and radiation, I wanted to hear what he would have to say. I was rather sorry that he did not cover the subject as listed: "Recent Trends in the Treatment of Cancer," and cover a little wider field rather than stay so closely to the radiation. But there are some thoughts that he has given us that are good, and a few things that I would like to mention. I do not know whether I am picking the wrong time to start an argument, but I believe any time is good.

In the first place, he speaks of sins of omission, and we can add to that, the sins of comission; because in the same paragraph almost he speaks of the alleviation treatment of known-helpless cancer patients. I think most of us who have been in cancer treatment work for many years and have made a study of it have about reached the place where we know whether there is any definite hope for cure of the patient or hope for definite relief of symptoms, and when a patient is beyond that place and somebody calls us and says, "Can't you give this patient some x-ray. It will help her morale or will help her feel that something is being done," my answer is, "Can't you operate on them just a wee bit more to build up their morale?" Let's not say that that is a morale-building proposition, at the expense of the value of radiation as seen by the public eye. When that is done it is definitely a sin of commission.

On the other side, sins of omission, he speaks of radiation and says that it must reach each cancer cell, and I would like to add to that, "and must be absorbed by that cancer cell in order to be effective."

Again he asks: What is the use of using some form of radiation that is absorbed mostly in the first 5 centimeters of tissue when the tumor lies below that 5 centimeters? At the same time, I would like to say: What is the use of treating the table under the patient? Let's adjust that wave length so that the greater amount of radiation is absorbed in the tumor mass itself and in the area to be treated. Even that is controversial. We will say it is 5 centimeters from the surface to tumor and 5 centimeters through tumor and then on through. We want that radiation absorbed in that 5 centimeters, between 5 and 10 centimeters.

My friend, Dr. Mayneord, at the London Cancer Hospital, said, "When you try to measure that, you are measuring the rate of change of the rate of change."

I said, "All right. Go ahead and measure." But that is what we want and we should use a radiation adjustable to that.

Then he speaks of the large and small fields and the variation in intensity with the size of field. This brings up the thing which is definitely controversial, and I am still reactionary enough to say that it is too bad that we have let our physicist friends talk us out of measuring radiation at the surface of the patient, and talk us into measuring radiation in the air, which means nothing at the surface of the patient and which means nothing in the change of the size of field. And it is only by knowing the radiation with back scatter on the field that you can determine skin changes that may be expected.

I appreciate that this is heresy, but nevertheless I still stick to it, that the radiation properly measured is measured at the surface.

Dr. Pettit: I wish to thank Dr. Williams for discussing my paper. Of course, as I said in my opening paragraph, a lot of these topics that I have mentioned are very controversial. The only thing I wanted to cite was trends as I have seen them.

With regard to the treatment of hopeless cases, I must say that within the past number of years — several years, at least — I have rather changed my attitude about giving treatment to hopeless cases. I have had a number of very startling surprises, and a number of cases that ten years ago I would have considered absolutely hopeless, I feel I have been able to render a great service; either a marked degree of palliation or even a cure.

I remember one woman I treated five years ago, advanced carcinoma of the uterine cervix, who was told by the Illinois Research Hospital to go home, there was nothing they could do for her. She is perfectly well today.

Another had an advanced recurrent carcinoma of the breast that was operated on at the Mayo Clinic, and she made sixteen trips back to Mayos for treatments. She had a tremendous edema of the arm and swelling of the neck and metastasis to her hip.

By intensive radiation without causing her very serious inconvenience, I was able to reduce that progress in the neck and shoulder and give her relief. Whereas, she had not been able to be out of bed, by treating that metastasis in her hip she was able to get up and lead a fairly comfortable life for nine months to a year, and died without any great amount of pain. I consider that is very much worth while.

What Dr. Williams says about measuring on the skin and the back scatter I most heartily agree with.

Thank you.

The optimist, seeing a half-filled glass of water will say it's half full, and the pessimist will say it's half empty.—*Town Meeting*

PROBLEMS IN THE CARE OF THE NEWBORN

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The problems in the care of the newborn are many and the more one studies this subject the more one realizes the importance of certain factors affecting these infants during this period.

The newborn period may be divided into two parts. (1) The first ten days to two weeks spent in the hospital, and (2) the next two weeks at home. For brevity sake I will discuss only those problems which arise in the hospital. The factors which enter into any phase of this problem are three:

1. Nursing supervision and care.
2. Adequate equipment.
3. Medical direction.

The nursing situation today is one which constantly needs our attention. Nurses are scarce and newborn supervisiors are at a premium. However the key to successful care of the newborn should depend upon one who has had special training in this field and who is able to instruct those under her in the importance of little things which mean so much in the management of a newborn nursery.

The second factor is adequate equipment. This does not mean elaborate and expensive apparatus, it does mean the absolute necessity of no overcrowding. A nursery may have the finest and most elaborate equipment but if too many babies are put into it, trouble starts, regardless of the precautions taken. Overcrowding means too close contact of the babies and usually this is followed by inadequate care and a breakdown of nursing technique. A definite limit must be placed on the number of babies in a nursery.

The third factor is medical direction. Too often the care of the nursery is left to the nursery supervisor and while this may be in good hands, it is not the proper arrangement. The management of this department should be under direct medical supervision. It is difficult for a supervisior to manage a newborn nursery if too many plans and techniques are ordered. These make for complication and confusion. One definite plan should be outlined for the normal newborn; if some special case presents itself, adjustments should be made. The physician in charge of the nursery should be trained and interested in the problem of the newborn so that situations which need study or change may be handled through the medical personnel.

These three factors must be regarded as essential before any discussion of individual problems is entered upon. Those I would like to discuss are: prematurity, the care of the skin, clothing, breast feeding, and circumcision.

The premature infant. What shall constitute a premature infant? This diagnosis should be applied to the product of conception after twenty-eight weeks or six and one-half calendar months or seven lunar months which will usually have a weight of 1,500 gm. or 3¼ pounds and a length of 35 cm. or 14 inches. There should be many concessions made to this definition. I feel that any infant whose weight is under five pounds should be treated as a premature infant and kept in the hospital until its weight approximates six pounds. One sign of prematurity which should be used more frequently is the lack of breast development in these infants. In observing a series of over 500 premature infants during a period of fifteen years, this sign was present in over 90 per cent. These small infants should be placed in a room apart from the general nursery because they need individual care and special nursing. A graduate nurse who has had special training in the care of premature infants should be in charge. They should not be handled too much and should not be removed from their cribs. The temperature of the room should always be between 75 to 90 degrees and a humidity of 65 per cent is best suited. The use of heated cribs or incubators is necessary and the liberal use of oxygen should always be available. This may be pure oxygen or a combination of 5 per cent CO_2. It may be necessary to give it continuously in some cases. I feel it is a good plan to use oxygen for a period of three to five minutes every two hours for the first few days on all infants under four pounds in weight. This seems to establish their respiration on a more constant basis and periods of cyanosis are much less frequent. Breast milk is the food of choice as it has been shown by clinical experience that there was greater susceptibility to disease and higher mortality rates in premature infants who

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received little or no breast milk. These babies should be fed small amounts by gavage or a medicine dropper. The amount of fluid depends on what the infant will tolerate, starting with one to two drams every two hours. This should not be increased too rapidly and the answer to how much and how often the baby should be fed is the individual infant itself. The early use of vitamins is necessary, such as concentrated vitamin D. Vitamin K used routinely is a good prophylactic measure. Vitamin C is preferably withheld for at least a week. The use of some form of iron such as ferri ammonium citrate 5 per cent solution should be started about the end of the second week. At times it is advisable to give small injections of subcutaneous fluid in 10 to 15 cc. amounts two to three times a day. In many communities, where hospital and nursing facilities make it impossible to care for premature infants, it would be a good plan to designate one hospital where these little ones could be given expert care. In Chicago this plan has worked out very well through the concentrated efforts of Dr. Julius Hess, Michael Reese Hospital, and the Health Department. A plan such as this is feasible for many smaller communities.

The care of the skin. Few physicians and hospitals are in agreement on the method to be used in the care of the skin of the newborn infant. It is a clinical fact that excessive irritation of the skin whether it be from bathing, application of antiseptic oils or ointments, the use of mercurial soaps, or the too brisk rubbing of the skin to remove the excessive vernix leads to the development of intertrigo, papules, benign pustules, or even impetigo. The infant's skin should be protected from excessive irritation regardless of the method of care adapted. In 1937 Sanford advocated the idea of no bathing of the infant's skin. It has been rather an interesting fact to have observed how the numerous methods for the care of the skin have been diligently used for short and long periods only to find that they all have many drawbacks. So many of these infants upon whom these various methods have been used have reacted with skin irritation difficult to control. In one institution with an annual birth rate of over 2,000 babies we have used the no bathing technique for the past six years and it has been gratifying to see how few if any irritations, pustular dermatitis and impetiginous lesions have existed. The plan we have followed has been to place the infant in the nursery as soon as possible after the delivery. There a nurse with care and no rubbing removes with cotton or gauze the blood and vernix. Let me stress the word care. No attempt to remove all the vernix should be made. This cleansing process is easy if it is done before the residue on the skin gets dry. The newborn skin after the delivery is soft and moist; no oils, ointments, soaps, sprays or water are necessary. After the original cleaning the infant is placed in its crib and from then on this is its private room during the stay in the hospital. The only time the baby is removed is for nursing. All the necessary nursing procedures and examinations are carried out in the crib. On first thought this no bathing procedure has objections, such as the baby seems unclean, the skin is dry, the odor is repulsive. All of these objections are unfounded. The dryness of the skin is present but as this superficial desquamation takes place there is beneath a soft, delicate, smooth skin. Sometimes the mother worries because the skin is dry. If the mother is told that this leads to less skin irritation and infection her fears are removed. This method of no bathing and less handling is a boon to the nursing situation; it reduces the work in about half. Instructions are given the mother on leaving the hospital to keep the skin dry at home during the first week.

The clothing of the newborn. This is also an important factor in the care of the skin. The garments alone if too bulky and heavy will cause excessive heat, resulting in perspiration which is usually followed by skin irritation. The clothing should be light in weight, easy to put on and take off, and not binding. How often have we seen some nurse struggling with a small shirt, trying to get the tiny arms through the sleeves. Then note the task of buttoning the shirt. After a few trips to the laundry, it is a buttonless shirt unless someone spends countless hours sewing them on. We have adopted a very simple garment, light in weight, no buttons, no pins, no sleeves, and only one small tie. This clothing does not bind the infant's arms and yet keeps it from rubbing its hands on its face and producing severe irritation. The only other article of clothing necessary is the diaper. The time consumed in changing these two articles is negligible

when comparing it to the shirt, nightgown, and diaper. My slogan is Keep the baby dry and cool. Do not wrap receiving blankets around them in the crib. Place covering over them, not too tightly and let them do a little kicking. The belly band is necessary until the cord falls off but after this it has served its purpose. The cord can be touched up twice daily with an alcohol sponge. On removal of the binder, it is one less garment to change, one less to get wet, one less factor to deal with in keeping the skin dry. While it is important to stress light clothing and little heat in the hospital, I feel we neglect a major point when we fail to impress the new mother about the child's garments at home. Too often the baby leaves the nursery without a blemish only to break out with a skin irritation within the first week at home. This results because the infant has been kept too warm. How many of you have noted all the clothing that goes with the modern layette? How many shirts, slips, bands, binders, stockings, booties, blankets, and snuggle robes are purchased. These are gifts of admiring parents and relatives. Nothing is too good or elaboate for the baby. Watch the nurse dressing the baby leaving the hospital. Regardless whether it is winter or summer, on go the garments. I often wonder if the designers of infants' clothing and equipment ever tried to use them. The more complicated the design the greater the cost, simplicity and serviceability sacrificed, the sufferer, the newborn infant. Let me impress on you the importance of keeping the infant cool at home. Remember the helpful nursemaid of years gone by is now working in the defense plant. You the baby's physician should safeguard the mother from the advice of all the relatives, neighbors, and well wishers.

Breast feeding. Breast milk is the ideal food for the newborn infant. We all admit it. We all know that infant mortality and morbidity rates, as shown by Grulee and his associates, are higher in the artificially fed infants. We know too that in the successfully breast fed infant the mother's well being is enhanced and her return to normal during postpartum is hastened by this physiological process. Knowing these facts what do we do to encourage breast feeding? Many obstacles beset the course of successful breast feeding. To name a few. Who educates the mother to the necessity of breast feeding her baby? Who instructs her in the care of her breasts before the baby arrives? So much can be done to correct depressed and inverted nipples, to prevent cracked nipples, and to get the mother accustomed to a certain amount of irritation of the breasts by careful instruction from the obstetrician. Together with this a good sales talk can be given the mother during this period to stimulate in her a willingness and positive desire to nurse her baby. This can all better be accomplished before the baby arrives than immediately after the delivery. This of course places the responsibility with the obstetrician because of his contact with the mother during the prenatal period. But I do not feel the great responsibility rests here alone. We in the hospitals are greatly to blame for the lack of breast feeding in our newborn infants. Too often during the first few days the baby is given too much fluid from a bottle. This feeding comes too easy, with too little exertion on the part of the infant. He is not satisfied to work hard at the breast for his sustenance and why should he when with a little crying he can compel the nurse to get the bottle. I feel that if we were not so quick with complementary and supplementary feedings during the first few days, if we only gave plain water instead of lactose, citrate, glucose, gelatin solutions, our percentage of successful breast feedings would increase. The initial weight lose should be thoroughly understood not only by the physician and nurse but by the mother, the father, and all of the relatives as well. In some nurseries where a daily quotation of the gain and loss is given out the interest becomes too great and instead of stimulating the breast to more secretion the result is just the opposite. A few years ago I took a series of about a thousand babies and divided them into five groups and to each a different prelacteal feeding was given. After making these observations as to weight loss, general well being, and aptitude for taking the breast, I felt no solution was much better than the other and that plain water served the purpose just as well. To satisfy myself that this weight loss was due to something more than the ingestion of fluids, I took a small group of twenty babies and gave them a hundred cubic centimeters of saline and 5 per cent glucose subcutaneously for the first four days. The weight loss of all these babies up to

the sixth day was 9 to 10 per cent. This weight loss I am sure is due to many factors other than intake of fluids. Such things as increased metabolic rate during the first few days, imperceptible perspiration, elimination of meconium, increased respiratory and muscular activity, all of these are more logical to explain this loss of weight. I also feel that if the policy to encourage breast feeding is known to the mothers in the hospital that an excellent "spirit de couer" can be elicited with one mother stimulating the other to a better mental attitude toward breast feeding. A routine plan for feeding the newborn is as follows: Nothing by mouth during the first twelve hours. It is during this time the infant can be observed for signs of cyanosis, cerebral irritation, and pulmonary accidents which would be contradictory to routine procedures. The second twelve hours give 1 to 2 ounces of plain water every four hours. The next twenty-four hours, place to breast every four hours, for only five minutes, giving 1 to 2 ounces of water after the nurse. During the subsequent days the breast feeding should be every four hours, omitting the 2:00 a.m. feeding.

In 1937 Blessing observed 493 cases of breast feeding for the purpose of determining just how long the mothers were able to successfully nurse their babies. In only seven cases were these mothers able to nurse their babies longer than nine months; 244 cases were weaned by the end of the third month; 365 cases by the end of the sixth month. These figures are discouraging. One factor which interested me was that the average age of the para was 27 years. I wonder what a similar study would show now when the age group has dropped to 18 to 20 years. Age is a big factor in the human as well as in the animal. Physiologically the young mother, all things being equal, has a better chance of nursing her baby.

The mother's state of mind is a very important factor. It is of course essential to be willing to nurse but it is not enough. The successful nursing mother undertakes her task with confidence as something natural, right and pleasant. She anticipates success and satisfaction in it, enough to compensate her for the inconvenience and she does not think too much about it. Worry and anxiety of any kind are fatal to successful nursing. It is not helpful to regard it as a difficult and doubtful scientific experiment. The mother who attempts to nurse while keeping note of every cry, every regurgitation of food, every stool passed, every quarter ounce gained or lost is doomed to failure more surely even than the unfortunate one who is forced to double the parts of nursing mother and harassed housewife. Other factors such as returning home to the "folks", living in crowded quarters, associating with older people who have not had their sleep and nerves disturbed by the wail of the lusty newborn; the need and desire of the mother to return to her job; the worry of the whereabouts and safety of the husband in service; all these at times will defeat the success of breast feeding. Knowing all of these obstacles, I feel with a little more diligence on the part of the obstetrician in his prenatal instruction to the mother, with the nurse holding back on the prelacteal feedings, except water, and making a concentrated effort to stimulate in the mother a willingness to nurse the baby, I am sure we will be more successful.

Circumcision. This operation is performed as a routine measure in too many cases and a review of some of the reasons for and against might make it a more selective procedure. If the question is asked, why do you want the baby circumcised? The answers are frequently: if it has to be done, it is better to do it while he is small; it is the usual thing to do to boys; it prevents masturbation; it will be easier to keep clean. We do know that it does not prevent masturbation. If the mother is instructed how to clean the penis there will be no difficulty. The operation is not without risk. Cases of diphtheria have been reported following this so-called simple operation. Cases of hemophilia have reacted poorly. What then should be our criteria for circumsion? If the foreskin is long with a pinpoint opening, and it is difficult to retract, then the advisability of operation should be considered. In the performance of this operation it is too often done in a very poor fashion, not always by the physician himself but delegated to an intern. To see these results at the end of two weeks one would hardly be satisfied with the work performed. One of the usual results is that too much of the foreskin has been removed. This produces too much scar tissue, and the penis in a state of erection resembles a chordee. Sometimes too much tissue is left on the dorsum with a large mass of tissue

hanging down in front of the glans. I feel that enough of the foreskin should be removed so that after healing the skin covers the corona of the glans. This makes the hygenic factor complete and still there is enough covering to preserve the sensititve nerve endings in the corona, Too much surgical scrubbing of the penis, abdomen and groin with soap and antiseptic solution produces too much irritation of the skin. This usually results in a pustular dermatitis on the fifth postoperative day. Smearing the dressing with vaseline also leads to rashes. The preoperative preparation should be limited to the cleaning of the penis only, keeping moisture and soaps away from the abdomen and groin. After the foreskin has been removed, then apply a piece of gauze soaked in tincture of benzoin. This makes for good hemostasin and the dressing does not have to be changed until it falls off at the end of one week. If the foreskin is left a little long, advise the mother to push the skin back once a day for about two weeks because preputial adhesions will form. Do not perform circumcision on even slight cases of hypospadius. The tissue which you remove may be necessary to use in plastic work in later years. My feeling about circumcision is that it should not be a routine procedure. Each case should be studied. If a house physician is delegated to do the work, at least see to it that he is shown how to do it. Do not be too rough in the preoperative care of the skin. Too much irritation leads to troublesome skin irritation.

These are only a few of the problems which occur in the newborn infant. There are many more but I feel if these are approached with good medical judgment and nursing care that their solution will be easier.

DISCUSSION

Dr. G. N. Krost, Chicago: In our nursery at Wesley the pediatricians have been given the privilege of taking charge of the nursery, with occasional exceptions when the obstetricians may have individual problems in certain babies.

In our nursery we wash the babies with plain water. We have individual crib technique, in these new plastic bassinets. We have tried non-bathing technique but the nurses seemed to object to it. They felt that the babies were not clean, but we did not give it a very thorough trial.

There was another short cut in cutting down nursing care, that we adopted, by following the suggestion of another hospital. St. Lukes has for a number of years done away with their cord band, after the first day, and they have used that, I think for four or five years without any danger and no cord infections. We have used it about six months, and it is quite a tremendous saving in time, and apparently is without risk.

We have had some rashes, when our hospital first opened, which were due to alkalinity of the baby garments and the linen but this was soon corrected. I think Sanford also found that he had that difficulty in the Presbyterian Hospital. A great many rashes were due to excessive alkalinity of linen. Now having the cooperation of the laundry engineer, these rashes have ceased to give us any difficulty.

We have all gone through the fads of feeding babies early, and I think we have more or less settled down to individualizing on a few babies, such as feeding babies that have been delivered by caesarean. The mothers are not likely to nurse them as quickly because of the anesthesia and opiates. By and large, we are giving the babies water until the breast milk comes in and if they fail to gain after the third to fourth day they are given complementary feedings, but we no longer use routine complementary feedings.

Dr. Paul E. Grabow, Chicago: I believe everything Dr. McEnery said, and especially do I believe the very first and last parts.

In the first part of his paper, he spoke about feeding of children, in order to prevent the initial weight loss of babies. I do not believe in feeding those children. I believe if a baby were to have food the first three days the mother would have it, but if she does not have it and there is a reason, then feed the baby. There are other reasons which I will not go into. I am glad to see some of the younger men thinking the same way.

Now about circumcision, there is one thing I think could be talked about a great deal more. I believe everyone should have an operation if it is necessary, but this routine of maltreating a human being I think is wrong. There are reasons sometimes, why a baby does need to be circumcised. There are babies, a few months old who have appendicitis and need to be operated. We do not operate on them routinely because we think they are going to have appendicitis, and I do not see any sense in routine circumcision at all. I think nature put that foreskin there for a purpose, and the purpose is good, and if there is any abnormality, it should be removed.

Dr. E. T. McEnery (Closing discussion): I want to thank the discussants for their kindness in not criticising the paper too severely.

Dr. Krost, you have not tried it long enough. It is rather surprising, I think, if you go into these hospitals and talk to the obstetricians and get their consent either to make it all or none, — you can not go part way; you have to keep water off them the entire stay in the hospital, and in some institutions, I mean where you have many men attending coming in, it is difficult to adhere to a definite technique; but I think if somebody is put in charge of the nursery and that person approaches the various obstetricians and

tells them about a plan which has been tried out in many hospitals, it is not in experimental stages now, it is a known fact you can prevent skin irritation by no-bathing; I mean by leaving that baby alone.

The difficulty is when somebody has to get a little water on them, somebody suggests a little ointment or mercurial soap. You can not be part way. You have to be all or none. I think if you would really try this no-bathing technique in the full sense of its meaning you would find out it works. There is no bathing while that child is in the hospital, and in fact I do not think you should give the mother a demonstration on the baby when it goes home. First of all, the mothers are taken into the room where it is too hot, they pay no attention to what the nurses say at all; secondly, you could do a better job by taking a doll and washing the doll than trying to wash a squalling baby.

So when they are in the hospital, I think no bathing from the first to the last day is the successful way.

Now about circumcision. I am grateful to Dr. Grabow for speaking of that. If some of the obstetricians could see some of the jobs they turn out they would be ashamed of them.

When I first started to think about this paper I was going to draw up some sketches of various circumcisions I have seen, and when I got to thinking of about ten different views I thought it would be one of these Krazy Kat cartoons, because it would be anything but plastic work.

A woman came into the dispensary not long ago and showed me the baby's penis, saying "the doctor had cut off the bottom of the penis and the baby did not urinate through the right place at all."

The child had not been circumcised at all, but she figured the doctor had injured the penis; but he had a hypospadius, and the mother felt the doctor had ruined her child's career by making a poor operation on the penis.

Therefore, when one sees these children, I think if you discuss it with the parents and find out why they want to have it done, why they thought it should be done, and explain to them that it is not always necessary. Talk to these mothers, and they think the children are born circumcised, they say "I have never seen a child that had a foreskin, and I think if it is not circumcised it will look strange later on in life," so I think if you would individualize this problem of circumcision it would save us a lot of trouble, and keep the children from a lot of irritation after circumcision.

A young Ensign, very insistent that he must have leave, was asked the reason by his Commanding Officer.

"My wife is expecting a baby," he replied.

"Listen, young man, remember this — you are only necessary at the laying of the keel. For the launching you are entirely superfluous."— *The Army Doctor*

VALUE OF SPOT FILMS IN RADIOGRAPHY OF THE GASTRO-INTESTINAL TRACT

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The use of spot films in radiology for aid in diagnosis was probably first used in Germany. The term is used in a rather general way to apply to films taken by the interposition and exposure of a film in front of the fluoroscopic screen, so as to obtain a radiograph which is essentially the same as the fluoroscopic image. They may be taken as a series of exposures on one film or as individual exposures usually on 5 x 7, or 8 x 10 films.

In about 1911 Drs. Case, Carmon, and others began using the spot film device for diagnostic purposes in this country.

In about 1914 spot film devices were commercially produced in this country so that at present many men are using them daily in varying degrees for aid in x-ray diagnosis.

The mechanism of spot film work as related to the gastro-intestinal tract is simple. The value is great in that a record of the fluoroscopic image can be made on a film for later study. Defects that are seen in the outline of any individual region of the gastro-intestinal tract vary in appearance on change of the patient's position or on pressure to the studied region.

The routine use of both thick and thin opaque material in the study of the esophagus is considered essential to good radiographic work. The patient is studied in a standing position if possible. The use of horizontal and Trendelenberg positions are of value in certain conditions.

Diverticula of the esophagus are easily demonstrated. They usually fill more satisfactorily with thick material than with thin material. Pulsion diverticula of the upper end of the esophagus in their early stage are nothing more than very small addition defects and retain the material for only a second. As they increase in size they are more easily filled. When they have sufficiently increased in size to produce symptoms they are usually easily demonstrated. They fill with opaque material and retain it for varying lengths of time. Many times a film taken at

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the time of fluoroscopy visualizes the diverticula more satisfactorily than one taken later without the aid of the fluoroscope. Traction diverticula fill easily and can be recorded on spot films. Rotation of the patient to the best position for visualization makes this method of added value.

In carcinoma of the esophagus the filling defect, although relatively constant, varies as the character of the material used and the position of the patient. The defect is usually irregular and sometimes annular. It can be differentiated from spasm by the constancy of the defect. The fluoroscopic image of the lesion is usually the most satisfactory.

In stricture of the esophagus the lumen of this structure does not vary much. However, the visualization due to the amount of opaque material in the stricture may vary a great deal. Therefore, a film taken at the time of best filling will be the most satisfactory.

Ulcers in the lower end of the esophagus are not common and are difficult to demonstrate. Although defects seen fluoroscopically will probably not be seen on films taken later so that a spot film may visualize the defect.

Foreign bodies in the esophagus of non-opaque type usually produce some obstruction to the descent of the opaque material. The point of obstruction and the defect in the column produced are of value on spot film study in that what was seen fluoroscopically is recorded on a film.

Defects produced in the esophagus by pressure from aneurysm, mediastinal tumors and abscesses are visualized most satisfactorily by variation in the position of the patient so that a record of your fluoroscopic findings taken on a spot film gives you the most accurate record of the lesion.

Cardiospasm, if of clinical significance, is usually satisfactorily visualized on ordinary film examination.

Esophageal varices are usually best studied by the use of thin opaque material with the patient in a supine position although the use of thick material in a standing position is sometimes of value. Films taken at the time of distention by thick opaque material may demonstrate the corrugated outline of the esophagus. Or the ingestion of thin opaque material may reveal the irregular "fragmented" appearance of the esophagus between the varices in this condition.

In the study of diaphragmatic herniae in the region of the esophygeal hiatus Trendelenberg's position with applied pressure over the stomach will usually fill the portion of the cardiac end of the stomach projecting above the diaphragm. The stomach should already have been filled with at least two glasses of opaque material. When there is difficulty in determining the location of a small round collection of material above the diaphragm after the stomach has been filled additional material ingested in Trendelenberg position will usually locate this material as being in the esophagus or in a small herniation of the stomach. A film taken at the time the additional material reaches the diaphragm is usually of definite diagnostic value. When the patient is prone with the head of the table below the foot some herniae will fill that otherwise will not.

Pathology in the stomach wall is demonstrated by distending the stomach with opaque material and noting any defect in the outline. Or the ingestion of a small amount of special opaque mixture for visualization of the mucosal pattern may be utilized.

In studying tumors of the stomach wall, both of the above methods as well as the variation of the patient's position to demonstrate a lesion are of value. Here again a defect seen on fluoroscopic examination may give a clue to the nature of the lesion. A medullary carcinoma produces a subtraction defect which is irregular and ragged with change in the peristalsis and the flexibility of the stomach wall. A scirrhous carcinoma usually produces less defect in the stomach outline and a diminution in size with marked decrease in peristalsis and the flexibility of the wall.

Benign tumors are usually differentiated by the appearance of the defect which they produce and the appearance of the adjacent mucosa. Spot-films taken with applied pressure satisfactorily visualize the defect and the adjacent mucosa.

Benign ulcers of the stomach wall are usually found in the region of the lesser curvature. Consequently, applied pressure and position of the patient standing, supine, or otherwise, make spot film study of extreme importance in that a record is made of any niche defect seen. Incisural defects may be radiographed in the most

advantageous position to visualize them and the associated pathology.

Probably the best method of demonstrating ulcers of the duodenum is by films taken with applied pressure over the bulb. The bulb is flattened by the pressure so that the niche is revealed prominently. Associated spasm sometimes makes ordinary films of little value. Even in the presence of adhesions and contractures about old ulcer pathology an ulcer defect can be more satisfactorily visualized by pressure.

Diverticula of the duodenum are usually visualized on routine films.

Inflammatory lesions of the small bowel due to the rapid flow of material and spasm at times lend themselves to satisfactory visualization on films taken at time of fluoroscopic examination.

Tumors of the small bowel are rare and if seen on fluoroscopic examination will usually be seen on routine small bowel films.

In routine studies the colon is studied by use of descending material. However, barium enemas are the most satisfactory for diagnostic purposes. It is very important that the spot films be taken as the colon is being filled to record any variation from the normal in the outline. Rotation of the patient into both obliques as the sigmoid region fills is very important due to the normal sigmoid looping and due to the frequent presence of redundancy. Rotation to the right as the splenic flexure fills and to the left as the hepatic flexure fills is indicated. The colon is preferably filled in the supine position. Manipulation during the filling of the colon is important. The distal ileum is filled routinely so that it is definitely determined that the cecum has been filled. At this time the entire course of the colon should be reviewed fluoroscopically with the patient in a prone position and if any unusual outline defects are noted additional spot-films should be taken. The use of pressure and manipulation is especially important in the study of the cecum in order to visualize any defect and to determine the relation of the appendix and distal ileum to this structure.

In carcinoma of the colon the subtraction type of defect is usually easily visualized unless the bowel is over distended. Irregular carcinoma defects are more difficult to demonstrate. A lesion on one surface of the wall may not be visualized unless seen in profile due to the projection of the mass into the lumen. Change in the mucosal pattern may be determined on good films. Complete or partial obstruction to the passage of the opaque material into the colon at times makes it difficult to determine whether the lesion is due to intrinsic pathology or due to spasm or kinking. At times the head of the column may be visualized so that the character of the lesion may be determined on spot films.

Polyps, unless large, are usually most satisfactorily visualized on contrast studies.

Intussusception readily lends itself to spot film work in that a film of the obstruction can be taken quickly and if it reduces itself there is still a record of the fluoroscopic findings. The barium column of an enema in this condition is obstructed and the head of the column becomes cup-shaped. A thin collar of opaque material surrounding the invaginated portion of the colon may or may not be visualized.

In many instances tuberculosis of the cecum and ascending colon can be best demonstrated on spot films due to the increased motility of the bowel. The cecum is of irregular outline with changes in the outline during the examination.

Fistula at any point in the course of the gastro-intestinal tract on spot films taken at the time of visualization of an abnormal tract may so identify the involved structures that later films or repeat examination will not be necessary.

The routine use of spot films as an adjunct to radiographic examination of the gastro-intestinal tract is definitely indicated. There are probably other conditions than those mentioned above where there is spasm, a confusion of shadows or an element of motion where the use of the spot film device will be found to be of value.

CHEST PHYSICIANS CANCEL MEETING

The American College of Chest Physicians, with a membership in 23 countries, has cancelled its annual meeting scheduled to be held at Philadelphia, June, 1945.

The Executive Council of the College voted to hold a business meeting of the Board of Regents at Chicago, June 17th.

EDEMA OF THE EYELIDS IN INFECTIONS OF THE PARANASAL SINUSES

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Edema of the eyelids might be caused by various diseases. We shall limit ourselves to a consideration of the lidedema in infections of the paranasal sinuses inasmuch as these instances are rather frequent and not always properly diagnosed.

1. *Pathogenesis.* — Among the paranasal sinuses infections of the frontal, maxillary sinus and the anterior ethmoid most frequently cause lidedema while in infections of the sphenoid and the posterior ethmoid the post-septal part of the orbit viz., the part of the orbit posterior to the orbital septum, is primarily involved and the lidedema, viz., the infection of the pre-septal part of the orbit, is of minor importance.

The question, which sinus most frequently causes lidedema depends on the age group of the patients under consideration. Inasmuch as a frontal sinus is scarcely developed prior to the seventh year of life, lidedema in infants and in children below this age limit can not be caused by the frontal sinus, but by the maxillary sinus or the anterior ethmoid which have considerable size in that age. On the contrary, in adults the frontal sinus seems to be the principal offender.

Generally speaking, the lidedema in infections of the paranasal sinuses might be due to two types of pathologic changes: a.) an ostitis of the walls of the sinus or b.) a thrombophlebitis of the anastomosing blood vessels. If there is an ostitis of the floor of the frontal sinus, or the roof of the maxillary sinus or the lamina papyracea of the anterior ethmoid, the infection readily spreads into the adjacent soft tissue of the eye lids causing a lidedema. These cases usually require rhinologic operations and will not be discussed in details.

More important and more frequent is the lidedema due to a thrombophlebitis of the anastomosing blood vessels. The blood vessels of the frontal mucosa communicate with the blood vessels of the upper lid, the communication being established by the blood vessels which pass through the floor of the frontal sinus. Likewise the blood vessels of the maxillary sinus communicate with the blood vessels of the lower lid, this communication being established by the blood vessels which pass through the roof of the maxillary sinus. These anastomosing blood vessels might carry an infection from the paranasal mucosa into the upper or lower lid respectively without causing microscopic changes of the bone. This spreading of the infection naturally is encouraged if there is a great number of anastomosing blood vessels. This is the case in young individuals while in old individuals the number of anastomosing blood vessels definitely decreases. Consequently, lidedema due to infections of the frontal or maxillary sinus occurs more frequently in young than in old individuals. Nevertheless, we had a chance to observe a lidedema due to a frontal sinusitis in a woman, 64 years old. The case is as follows:

Case 1. R. S., 64 years old, white, female. She had suffered from high blood pressure for many years, but there was no diabetes. Two weeks ago she had intense headaches and the right eye was inflamed, but there was no fever. The diagnosis of a dacryocystitis was made.

The rhinologic examination revealed a slight deviation of the septum to the right. There was no pus in the nose, but there was a small amount of pus in the right side of the epipharynx. The temperature was normal. There was no tenderness of the trigeminal branches. The right upper lid was edematous and red and so was the right lower lid, to a lesser degree. There was some pus at the openings of the lacrimal canaliculi, but no pus could be expressed from the tear sac and the skin over the tear sac was normal. There was some proptosis of the right eye and a slight displacement downward. The right conjunctiva was markedly inflamed. The x-ray picture showed a cloudiness of the right frontal and maxillary sinus. After application of heat and ephedrine in the nose the lidedema decreased markedly, but there was pus in the right middle meatus of the nose. Two days later the eye was normal, but there was yet pus in the right nostril. After a simple shrinkage of the nose the patient was cured in one week. However, one month later the eye lids on the right side again were swollen and inflamed. The temperature was normal. During that attack, however, pus could be expressed from the tear sac through the superior canaliculus. The diagnosis of dacryocystitis was made. Simple application of heat cured the patient and there were no more recurrences.

In the case presented the rapid cure after application of conservative measures proves that the lidedema was not due to an ostitis of the

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floor of the frontal sinus, the infection was carried rather from the sinus into the lids along the anastomosing blood vessels although usually the anastomosing blood vessels are obliterated in that age. The dacryocystitis which caused the second attack of lidedema, originated probably from the conjunctivitis in the course of the first attack. Both attacks resolved after application of heat and shrinkage of the nose; no sulfa drugs were administered.

While there is a direct communication between the blood vessels of the frontal and maxillary mucosa on one hand, and the blood vessels of the lids on the other hand, the blood vessels of the ethmoid mucosa anastomose directly with the blood vessels of the periorbit viz., with the blood vessels of the periosteum of the orbit, the anastomosis being established by blood vessels which pass through the lamina papyracea. The number of the anastomosing blood vessels is great in infants and decreases gradually in the later periods of life. Therefore, in infants and in young children infections of the ethmoid frequently are carried into the orbit along the anastomosing blood vessels while in adults infections of the orbit, originating in the ethmoid, are more frequently due to an ostitis of the lamina papyracea.

When the infection has invaded the orbit, it causes in mild cases a congestion in the space between the periorbit and the lamina papyracea. In that space the infection invariably spreads forwards, passes the orbital septum and causes a lidedema.

On account of the numerous anastomosing blood vessels between the ethmoidal mucosa and the periorbit, the lidedema is perhaps the most conspicuous symptom of ethmoiditis in infants and young children. In addition there might be occasionally meningeal symptoms, a high degree of fever and exophthalmos. All these symptoms give the impression of severe illness. Nevertheless, the symptoms usually disappear after simple conservative measures as shrinkage of the nose and administration of sulfadrugs. Surgery is rarely required, in many cases it is more harmful than beneficial to the patient.

We saw a number of instances of that type. Two cases might be reported to demonstrate the protean symptomatology in ethmoiditis of infants.

Case 2. D. G., 2 years old, white, female, had a head cold for one week. Epiphora and redness of the right eye were noticed. In addition there was a slight degree of fever and vomiting. In the course of several hours both eye lids became swollen so that the right eye was shut closed. Two days later there was considerable swelling and redness of both eye lids on the right side, the conjunctiva was red, the pupils equal. There was no pus in the conjunctival sac. The nasal mucosa was edematous and there was a mucopurulent discharge from the nose. The pharyngeal mucosa was red and the tonsils edmatous; the temperature was normal. Shrinkage of the nose was applied. Two days later the lidedema had markedly decreased and three days later the lidedema had completely disappeared. The x-ray film showed a haziness of both ethmoids and both maxillary sinuses; the frontal sinuses were not developed yet.

Case 3. McD., 3 years old, white, male, had a head cold and fever up to 102°. A day later the temperature fell to 99°, but 4 days after the onset of the cold the temperature again rose to 102.5° and a swelling appeared in the inner angle of the right eye above the internal palpebral ligament which rapidly spread over the entire upper lid. There was a slight proptosis of the right eye, but there was no chemosis and the eye grounds were normal. The nasal mucosa was red, but there was only a small amount of pus in the nose. There was a leucocytosis of 18500 leucocytes. The x-ray showed that frontal sinus was not developed while the ethmoidis were cloudy. Sulfadiazine was given and shrinkage of the nasal mucosa instituted. Five days after the onset the temperature was 101°, but the child was drowsy and a spinal puncture was performed. In the spinal fluid there were 88 lymphocytes, 88 mg. glucose and the total protein was 0,014 mg. No surgery was performed, but sulfadiazine and shinkage of the nose were continued and the boy was cured about 2 weeks after the onset of the disease.

In both cases the lidedema indicated an ethmoiditis and in both cases a cure was accomplished by simple conservative measures although in case 3 there were marked systemic symptoms as fever, leucocytosis and meningeal symptoms. The treatment consisted of shrinkage of the nose and administration of sulfadrugs, the former being of major importance.

The symptomatology becomes different if the infection spreading along the anastomosing blood vessels from the ethmoid mucosa into the orbit, causes an actual accumulation of pus between the lamina papyracea and the periorbit, that is, a subperiosteal abscess of the orbit. In these instances the disease continues for a longer period of time, exophthalmos, displacement of the eye and transitory eye muscle paralysis are more

prominent than lidedema. The systemic and meningeal symptoms are marked, which, however, are not significant for subperiostal abscess as these symptoms might be very conspicuous even in simple congestion of the orbit as proved by case 3. Subperiosteal abscesses of the orbit are not common either in infants or in adults. The following case concerns an infant.

Case 4. K. U., 8 months old, white, male. Three weeks ago the right eye suddenly proptosed but there was no lidedema, no redness of the lids and no pains. The exophtalmos subsided a little, but pus was found in the conjunctival sac every second day. There was no fever at any time.

On admission, on November 1, 1940, there was a marked exophthalmos on the right side. The eyelids were red and cyanotic, there was some restriction of the motility of the right eye the reaction of the pupils to light and accommodation was normal and the right papilla was slightly red. Nose and ears were normal. The child was put on sulfathiazole. The x-ray study on November 5th, revealed normal optic foramina, but a definite cloudiness of the right ethmoid and the right maxillary sinus. There was purulent discharge from both nostrils. On November 6th, a secretion was noted from both ears and in the pus diptheroid bacilli and staphylococci were found. On November 7th, the temperature rose to 102°, but was normal on the next day. On November 13th, the temperature again rose to 102° and fell on November 14th to 101°. The exophthalmos did not show any changes. On November 18th, the temperature rose to 105°; there was an enormous discharge from the nose and from the ears, but the child was apparently comfortable. On November 19th, the temperature was normal. On November 27th, sulfathiazole was discontinued and immediately the temperature rose to 102° and 103°, but the child did not show signs of discomfort. The exophthalmos was not changed; the right eye was displaced downwards, and there was a marked abducens paralysis on the right side. There was an intense discharge from nose and ears. After administration of sulfathiazole, the temperature again became normal but there was no change of the other symptoms. On December 7th, the exophthalmos had markedly subsided, but was again marked on December 9th. The eyelids were normal, there was no fever, but the child was irritable. If sulfathiazole was discontinued the temperature immediately rose up to 104°. On December 27th, there was a marked edema in the inner angle of the right eye, the exophthalmos did not change, there was only slight rise of temperature although sulfathiazole was not given. On the next day the temperature became normal but since January 12th there were daily rises of temperature up to 100.6°. The eye symptoms did not improve.

On January 18th, the orbit was explored. Immediately behind the posterior lacrimal crista a narrow fistula was found in the lamina papyracea leading into the ethmoid. At that site the periorbit was torn and the orbital fat protruded through the perforation in the periostreum. A piece of the fat was removed and the microscopic examination revealed a great amount of polymorphonuclear leucocytes within the capillaries of the fat, forming leucocyte-thrombi in some blood vessels. The wound was drained and partially closed. On January 22nd, the dressing was changed. There was no fever, but the exophthalmos had increased and the lid edema was very marked. A greater part of the wound was open and the child was again put on sulfathiazole. In the next days the eye symptoms subsided to a certain extent and there was no fever. On February 11th the temperature rose to 103° and there was an intense discharge from the nose. The exophthalmos had almost disappeared, but the edema of the right upper lid was marked. On February 17th the temperature was 101° to 102°, the child was irritable, both eyelids were edematous on the right side, the exophthalmos was even more marked than prior to the operation, there was a slight conjunctivitis and a marked discharge from the nose. Shrinkage of the nose and infrared heat were applied. On February 21st the temperature was normal, there was no discharge from the nose, no orbital symptoms except a marked exophthalmos. In the next days the eye symptoms subsided and the child was discharged, slightly improved.

In the following weeks, there was a continued improvement without further medication. On April 18th, the right eye receded to its normal position but there was a definite swelling in the inner angle of the right eye, with a fistula which drained occasionally. Gradually these symptoms also subsided, and on June 6th, 1941, the child was cured.

In the presented case, the ethmoid did not cause any congestion of the orbit, nor was there any pus. The findings were as follows: there was a narrow fistula in the lamina papyracea and the periorbit was adherent to the fistula so that it was torn at that site during operation and the orbital fat protruded. The orbital fat was not inflamed, but the capillaries showed a conspicuous filling with leucocytes. It can be reasonably assumed that there was a subperiosteal abscess, that the pus escaped through the fistula of the lamina papyracea into the nose so that the abscess resolved with formation of scars between the ethmoid and the orbit.

According to the diagnosis the principal symptoms were exophthalmos, displacement of the bulb and a transitory paralysis of the abducens. The fever was marked, but the meningeal symptoms were only suggested. The condition lasted more than six months. This finding is contrary to the finding in simple congestion of the orbit.

Sulfathiazole had a definite effect on the fever, but no effect on the eye symptoms, while shrinkage of nose, infra-red heat and proper diet were of benefit. There was no improvement with surgery, nor did it decrease the duration of the disease. Inasmuch as at the operation the thin periostium was injured it was to a certain extent harmful. This indicates that in orbital infections of infants, originating in the ethmoid, conservative measures should be employed as long as possible, viz. as long as meningeal or systemic symptoms or persistence of lid edema do not render surgery imperative.

2. *Pathology.* — When the infection travels along the anastomosing blood vessels from the sinus mucosa to the lid, a simple edema develops within the pre-tarsal portion of the lid. The skin of the lid is bulged out and red. Even in marked edema the sulcus tarso-orbitalis can be seen although somewhat flattened, and the free margin of the lid is involved only to a small extent. This finding is important as in exophthalmos the lid is also bulged out and might be even pinkish red. However, in exophthalmos the sulcus tarso-orbitalis becomes definitely flattened even in the incipient stage of the disease. Furthermore, in lidedema due to infections of the free margins of the lid (hordeolum, chalazion, herpes) the edema is most marked at the free margin of the lid, a site which in lidedema of paranasal origin is involved to a minor degree.

If the infection has spread along the anastomosing blood vessels the lidedema usually resolves spontaneously if the sinus infection subsides. That is the usual finding. If the edema spreads over the forehead, cheek, or the bridge of the nose the cause is more than a simple acute sinusitis and requires attention from the rhinologist. In rare instances of that type the lidedema progresses to the formation of an abscess.

However, if the lidedema is due to a necrotic ostitis of the underlying bone it usually progresses to the formation of an abscess which, in turn, may result in a fistula of the skin unless the underlying ostitis is properly treated. Even in these cases the abscess does not perforate the tarsus nor the conjunctiva of the lid, but almost invariably the skin.

3. *Localization of Lidedema.* — In progressed cases the edema involves the entire length of one or both eye lids and no conclusions can be drawn concerning the origin of the edema. If, however, there is a chance to observe the initial stage of the edema some conclusions of practical importance can be deducted. Although the lidedema per se like any other single symptom does not allow a definite diagnosis the following rules may be of help:

1. Lidedema due to infections of the maxillary sinus involve the lower lid first, while lidedema due to infections of the frontal or anterior ethmoid sinus involve the upper lid first.

2. Lidedema due to infections of the ethmoids involves the skin over the frontal process of the maxilla and extends rapidly lateralwards. It is localized above the internal palpebral ligament.

3. Lidedema due to a dacryocystitis involves the same area as lidedema due to ethmoiditis, but it is localized below the internal palpebral ligament.

4. Lidedema due to infections of the frontal sinus makes its first appearance either in the mesial or in the lateral portion of the upper lid. If the temporal recess of the frontal sinus is not developed or not infected the lidedema involves almost the same area as the lidedema in ethmoiditis. However, in frontal sinusitis the skin over the frontal process of the maxilla is not involved or is involved to a lesser degree. If the infection involves a well developed temporal recess of the frontal sinus the lidedema makes its first appearance in the lateral portion of the upper lid.

These rules will be of help in determining the proper diagnosis and treatment in an individual case. The vague diagnosis of "lidedema" should not be made, if possible, and should be replaced by a more exact description of the type and localization of the edema.

DISCUSSION

Dr. Hans Brunner, Chicago: There are two comments I wish to make on this subject. In Dr. Folk's paper, lid edema due to thrombophlebitis of the anastomosing blood vessels was particularly emphasized. In such instances the lid edema must be considered as a collateral hyperemia which surrounds an accumulation of pus; hence, the edema subsides when the localized accumulation of pus within the sinus is properly drained. A transformation of the collateral hyperemia into an actual lid abscess is a rare occurrence. If, however, the lid edema is due to osteitis of the bone, the collateral hyperemia of the lids usually changes into an abscess which either perforates through the skin or requires incision. The incision

should always be followed by examination of the underlying bone to ascertain whether osteitis or sequestrum is present. If bone pathology is found, simple incision of the skin is not sufficient and proper drainage of the paranasal sinus should be performed.

I should like to stress the last statement of Dr. Folk. The diagnosis of "lid edema" has no more meaning than the diagnosis "perforation of the ear drum." Every otologist knows that a perforation in the anterior and inferior quadrant of the drum indicates quite another disease than does perforation of Shrapnell's membrane. Likewise, edema of the lower lid means something quite different to edema of the lateral portion of the upper lid, as pointed out by Dr. Folk. Obviously further observations are necessary to judge whether the clinical diagram presented by Dr. Folk, is correct or not; however, at present it is unquestionably helpful.

GONORRHEAL OPHTHALMIA NEONATORUM

A Case Report

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CHICAGO

This case of gonorrheal ophthalmia neonatorum is presented because the blindness which ensued could, in all probability, have been prevented if proper therapeutic measures had been taken. The present-day relative rarity of extensive destruction of the eyes in this disease is indicated by the fact that only five similar cases have been recorded in Illinois in the past eleven years.

CASE HISTORY

The infant, a white male, was born in December, 1943 in Central Illinois. The birth certificate stated: "Treatment of eyes at birth — silver nitrate, one per cent." The mother denied having had any vaginal or urethral discharge prior to the delivery. The latter had been entirely uncomplicated, as far as she knew.

She stated that her baby had a "cold in his eyes" a few days after birth, and that a bloody purulent discharge was present in both eyes until three weeks post-partum. Her attending physician allegedly informed her that this was not unusual. As a result, ophthalmological consultation was not had until the child was three months of age, by which time irreparable corneal damage had occurred. Six months later the case was referred to the Illinois Eye and Ear Infirmary.

Ophthalmological Examination. — On admission, the right eye showed a staphyloma of the cornea of such magnitude that the lids could not be closed over it. The left eye was in a state of phthisis bulbi. The mother stated that the left eye had previously had a "bulge", but that it had "burst" spontaneously. From the behavior of the child it was obvious that it did not perceive light.

The child fortuitously died in his sleep during his second night at the Infirmary. No operative procedure had been performed, and no cause of death was apparent. The coroner's diagnosis was status thymico-lymphaticus.

From the Illinois Eye and Ear Infirmary, The University of Illinois.

COMMENT

In the case presented, the presence of a Neisserian infection in the mother had not been recognized. According to the birth certificate, the newborn did receive the Crede treatment. The course of the ophthalmia was so characteristic of Neisserian infection that the other etiological possibilities need not be considered. The occurrence of gonorrheal ophthalmia in a newborn that had received the prophylactic treatment forces one to assume that either the technique of the latter was faulty or that the treatment had been given several hours after the infection had taken place.

In all probability, the diagnosis of gonorrheal ophthalmia could have been made during the first week post-partum, simply from the clinical findings. The reaction which may follow the use of silver nitrate does not persist for more than a day or two. It is to be remembered, also, that there is an absence of tears at birth. Consequently, any conjunctival discharge in a newborn, even watery, is to be looked upon with suspicion. The Department of Public Health of the State of Illinois considers any inflammation, swelling or discharge of the eye or eyes present "at any time within two weeks after the birth of the infant" as ophthalmia neonatorum.

Gonorrheal ophthalmia neonatorum begins as a conjunctivitis. Corneal involvement, the cause of blindness, is always secondary to the conjunctival infection. Prompt efficient treatment, instituted while the infection is yet confined to the conjunctiva, can usually prevent corneal complications. The urgency with which treatment must be started is indicated by the Department of Public Health regulation which states that "it shall be the duty of any physician . . . . . observing or having reasonable opportunity to observe ophthalmia neonatorum . . . . . *within six hours thereafter to report in writing or by telephone followed by a written report such fact to the local health author-*

ities. . . . .". The Department of Public Welfare has no record of the case discussed herein having been reported to them.

SUMMARY

A case of gonorrheal ophthalmia neonatorum is reported in which blindness resulted.

In violation of the laws of the State of Illinois, the case was not reported to the local health authorities, nor were the proper therapeutic measures instituted.

IRRITATIVE EFFECTS OF SMOKE FROM TOBACCO TREATED WITH GLYCERINE AND DIETHYLENE GLYCOL[1]

W. D. McNALLY, M.D., W. BERGMAN, Ph.C.,
R. H. K. FOSTER, M.D.[2]
CHICAGO

Since performing experiments several years ago comparing the irritating properties of smoke from tobacco treated with the hygroscopic agents, glycerine and diethylene glycol, several papers have appeared on the subject, and it seemed advisable to report our own results even at this late date.

Mulinos and Osborne[1] found smoke from diethylene glycol-treated tobacco less irritating than smoke from glycerine-treated tobacco. They used edema in rabbits' eyes as the criterion. Flinn[2] cited clinical experiments indicating less irritation when diethylene glycol was used. Wallace, Reinhard, and Osborne[3], using the Mulinos and Osborne technique, confirmed the latter's results, saying that edema was the most definite evidence of irritation. Ribeiro[4] advocated the use of diethylene glycol in cigar tobacco instead of glycerine. This recommendation was based on the presence of acrolein in cigar smoke. However, Flinn stated that acrolein occurs in all tobacco smoke regardless of the hygroscopic agent.

In contrast to the above conclusions, several authors found no significant difference between the two types of smoke. Sharlit[5] gave the opinion based on his own subjective experience that no differences existed. Ballenger and Johnson[6], in a clinical report, stated that the hygroscopic agent was not a significant factor in nasal or throat irritation caused by tobacco smoke. They found that omission of either hygroscopic agent gave evidence of increased irritation both objectively and subjectively. This observation runs parallel to that of Titkemeyer[7] who observed higher combustion temperatures in untreated tobacco and explained the observed increased irritation on this basis. Holck and Carlson[8], using salivation in human subjects as the criterion of irritation found equal irritation from glycerine and diethylene glycol-treated tobaccos but slightly greater irritation (though not significantly so) from untreated tobacco. Haag[9], using hyperemia in rabbits' eyes as the criterion, found no difference. He stated that hyperemia is the "cardinal criterion" and that edema varies too greatly to be useful. Actually, his results gave a slight edge to glycerine-treated tobacco both for irritation and toxicity (solution of absorbed smoke), although the differences were obviously not significant, and he made no claim beyond "no significant difference". Ballenger[10],[11], in further clinical studies, reported no difference. Analogous to Haag's work, he found slightly more unfavorable results from untreated tobacco, somewhat less from diethylene glycol-treated tobacco, and least from glycerine-treated tobacco, but these differences again were slight and not significant. In a discussion of Ballenger's paper, Jarvis pointed out that moistening about 1/4 inch of the mouth end of the cigarette with saliva greatly reduced the number of smoke particles coming through with each puff and that "smokers' coughs" tended to clear up using this technique. Weatherby[12], using the trypan blue technique involving intradermal injections in rabbits' ears, also found no difference between the two types of smoke.

This brief review has been made to show the lack of agreement among observers. Our own work, done prior to the publication of all but Mulinos and Osborne's report, is in complete harmony with the view that no significant difference exists. Many of the authors cite the difficulty in interpreting the observations, both clinical and laboratory, yet Mulinos and Osborne were able to note 8 different degrees of edema! If differences in effects are so slight as to be difficult to classify by the majority of observers, how can such differences have *any* practical significance? Furthermore, proof of the significance of a very slight difference would,

1. These experiments were performed in 1934. The data have been used in court testimony.

2. Present address: Hoffman-La Roche, Inc., Nutley 10, N. J.

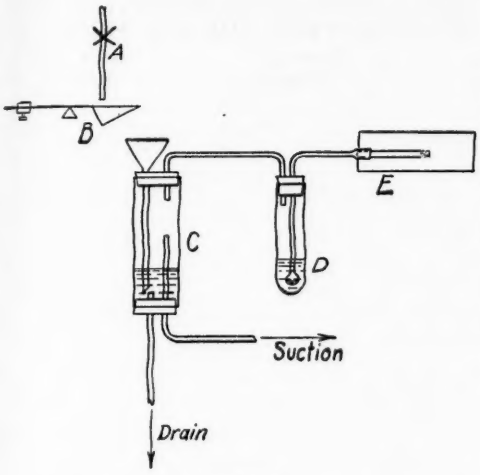

FIGURE I
DESCRIPTION OF APPARATUS

Constant suction from a water pump is applied as indicated in the sketch. When reservoir C ("a water valve") is empty, air is sucked in both through the funnel and through the drain. When water partly fills the reservoir as shown on the sketch, air enters through the cigarette at E and bubbles through saline solution D. Water flows intermittently into the reservoir C by means of the trip bucket mechanism B, the water flowing constantly from source A. To prevent drafts, the cigarette at E is surrounded by a jacket open at both ends.

on account of the observational errors, require a great number of observations. Our experiments, though not extensive, gave no suggestion of any advantage to the diethylene glycol-treated tobacco.

We followed the technique of Mulinos and Osborne as closely as possible, except, however, that we used hyperemia as the criterion of irritation rather than edema. The apparatus was constructed according to their description. Figure No. 1. Briefly, the apparatus consisted of a device for the intermittent puffing of cigarettes, the effluent smoke for 5 successive cigarettes being absorbed in 3 cc of normal saline solution. Cigarettes were made from a weighed amount of tobacco in a hand-operated cigarette roller. A stock of untreated cigarette tobacco was used, and portions of this were treated to give concentrations of 3 and 5% of the two hygroscopic agents, glycerine and diethylene glycol.

Two or three drops of the saline solution containing absorbed smoke were instilled into the conjunctival sacs of rabbits' eyes. Observations were made for inflammatory reactions, examining these eyes at intervals until recovery had occurred (about 1 hour). In each rabbit, the drops were instilled in the right eye, and the left eye served as the untreated control. A transient blepharospasm always occurred (as it does even from saline); but after a few seconds, the lids opened, and there were no apparent differences from the untreated eyes in the width of the palpebral fissure. The average time to the maximum degree of irritation was 10 minutes.

The gaging of the degree of inflammation was not easy. The mere manipulation in everting the lids caused some hyperemia and blepharospasm. This of course gave difficulty in interpreting slight reactions even though the same thing occurred with the control eye. The manipulations were naturally as uniform as possible. We have used the symbol 4+ for the maximum irritation observed. This was much less than the severe injection and chemosis that may be observed with a strong irritant such as mustard oil. Usually, there was no edema or lacrymation, so that hyperemia appeared the best criterion to employ just as concluded by Haag. This appeared first on the palpebral conjunctiva, and in stronger reactions, on the bulbar conjunctiva.

The data from the tests are given in the table. The data have been averaged, and the results show no significant differences in the degree of irritation. The untreated tobacco gave a 1.2+ degree of irritation. The glycerine-treated tobacco gave 1.8+ and 1.1+ for the 3% and 5% concentrations, respectively, and the corresponding values for diethylene-treated tobacco were 1.3+ and 1.6+. The P* value for the comparison of the 3% concentrations is 0.8. Although the 5% glycerine showed less irritation than the 5% diethylene glycol, the P value for the difference is 0.2, which indicates there is definitely no significance to the difference.

SUMMARY

Experiments were performed on the irritating properties of smoke from tobacco treated with

*P equals probability differences, are not statistically significant unless P is less than 0.05.

IRRITATIVE RESPONSES OF RABBITS EYES CAUSED BY INSTILLATION OF SOLUTIONS CONTAINING ABSORBED MATERIAL FROM TOBACCO SMOKE

Condition of Tobacco	Rabbit Number	Maximum Irritation	Mean Max. Irritation	
Untreated	1, 3, 6, 10, 11	+, +, +, +, 2+	1.2+	±0.2
3% Glycerine	2, 7, 12	±, 2+, 3+	1.8+	±0.8
5% Glycerine	2, 4, 5, 8, 9, 9, 11, 14	±, ±, +, +, 2+ +, +, 2+	1.1+	±0.2+
3% Diethylene Glycol	3, 8, 10, 13	0, 4+ +, 0	1.3+	±0.9
5% Glycol	1, 4, 6, 7, 10 11, 15, 15	3+, +, +, +, 3+ +, +, 2+	1.6+	±0.3+

Inflammatory responses:

4+ = "considerable" inflammation of both bulbar and palpebral conjunctiva but with very little endema. The other symbols indicate correspondingly less irritation.

glycerine and diethylene glycol using the technique of Mulinos and Osborne. We could find no significant difference between the smokes from these two types of tobacco or between either of these and the smoke from plain tobacco.

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Physical Medicine Abstracts

John S. Coulter, M.D.

PARIETAL NEURALGIA

R. H. McDonald, M.D.

In CLEVELAND CLINIC QUARTERLY, 12;1;31
January, 1945

Parietal neuralgia is induced in the great majority of cases by some pathologic process or by pressure upon the spinal nerve root, usually at the point where it emerges from the intervertebral foramen. The commonest cause in older patients is undoubtedly a hypertrophic arthritic process of gradual encroachment upon the foramen. In younger patients the question of postural strains must be considered. Structural scolioses, injuries and tumors of the bone may be readily recognized, but functional scoliosis may escape notice. This will only be seen by careful examination of the patient's back and posture. Any complete physical examination must include careful observation of the patient's back, preferably with the patient standing in his bare feet.

Treatment of parietal neuralgia depends upon the process which has caused it. In the arthritic patient the use of heat and massage over the affected area will be of value. Limitation of the movement of the spine by adequate braces may be useful, and x-ray therapy to the spine has apparently been beneficial. Avoidance of prolonged walking and standing and a period of recumbency in a firm bed may be useful from a therapeutic viewpoint and also as an aid in diagnosis. In the case of younger persons, especially those of asthenic type, the use of graduated postural exercises is of chief importance. By their use muscle tone is improved, and ligamentous strain is relieved. Marked improvement of peripheral circulation is frequently seen in association with deep breathing exercises, and an improved position and circulation of the abdominal viscera often alleviates the indefinite gastrointestinal symptoms of which these patients complain. A short lower extremity may be corrected with a lift in the heel sufficient to cause the pelvis to be level and to restore the symmetry of the spine, thus overcoming the mechanical basis for strain. Adequate rest is also beneficial and may be all important in the chronically exhausted individual.

EVALUATION OF TREATMENT IN THROMBOANGIITIS OBLITERANS
(Buerger's Disease)

Emil J. C. Hildenbrand, M.D., Washington, D. C.

In SOUTHERN MEDICAL JOURNAL, 38;3;179
March, 1945

Exercises of the Buerger-Allen type modified by Wright are indicated in all cases. Baths should be limited to compresses of saline or boric acid if ulceration and infection are present for 30 minutes twice a day. For mild cases, some of the advertised warm mineral baths are beneficial, but similar results can be obtained in a bath tub or whirlpool bath. Water will macerate poorly nourished tissues and open avenues of infection. The passive vascular exercising apparatuses are of value only when the predominant findings prove to be organic occlusion and the vasomotor have been eliminated, as they increase blood flow through relatively rigid arteries by rhythmically increasing intra-arterial pressure or decreasing the pressure within the ischemic tissue. Ultraviolet blood irradiation brings some promise, but further investigation is necessary. Heat is very helpful in all cases, but its proper application is essential. The affected

extremities should be exposed to none other than room temperature or below. A beneficial reflex vasodilatation by immersing opposite extremities in water at 113° F. may be accomplished. Local heat to the trunk by means of blankets, hot water bottles, electric pads, or heated cradles, is to be encouraged, which also accomplishes vasodilatation. Using the desired results of the typhoid vaccine treatment as a criterion for the proper treatment of thromboangiitis obliterans, I have used the fever cabinet. A patient covered with blankets and electro-magnetic cable with affected extremities exposed can expect the same result except be a little more uncomfortable because of weight on his trunk.

ADVANCE IN THE PREVENTION AND TREATMENT OF POLIOMYELITIS

James L. Wilson, M.D., New York, N. Y.

In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, 44;1;70
January, 1945

I have chosen to twist the title assigned to me to allow me to confine my discussion of this most interesting and complex disease to a consideration of the therapy of poliomyelitis in the light of the advances in our theoretical knowledge of the disease in the last few years. No research on my part justifies my assuming to address you on this subject, and I can only claim a great and constant interest as a close clinical observer of the disease.

I will start with a summary which may seem most pessimistic and depressing and quite lacking in matter for headlines. Although a great deal that is new has recently been learned which sooner or later will inevitably lead to our ability to control this dreaded disease, it seems to me that at present what we know makes us have less confidence in ourselves and feel less sure of being able to do anything to control the spread of the disease or influence its course than we felt five or ten years ago.

Recently in the various attempts to rationalize the so-called Kenny treatment, belief has been expressed that there is no true paralysis in poliomyelitis but that the resulting weakness was as I would express it a "pseudo-paralysis," due to some mental inhibitions or "alienation" derived from opposing tender muscles. I should like to emphasize the fact that the only pathological change that we know of that is permanent and that does not disappear after recovery from the acute stage of the disease is a loss of those anterior horn cells and we should tie to this and not be misled by physiological sophistries.

There is now much evidence to convince us that the primary pathology is in the motor cells of the anterior horns and that in all the other changes are secondary. Some very beautiful experimental work in monkeys has been carried out which I cannot take time to review in detail but which demonstrated that the virus first damaged the anterior horn cells and that the interstitial changes were secondary and did not occur in spite of inoculation with potent virus in sections of the brain or the cord where the large motor cells had been destroyed previously. All this makes us feel quite surely that these many attempts to increase the blood supply to the great motor cells were based upon a misconception of the pathogenesis and were quite futile.

We come to a discussion of the Kenny phenomenon which is the latest attempt at therapy and of them all the most popularized by the lay press. It is indeed a phenomenon, and is of great interest in illustrating how we as a nation think and act as well as in its relation to this important disease. First, it demonstrates a commendable open-mindedness that physicians would seriously consider the claims of a nurse completely untrained in medicine or in basic science and from the time she first came to our country most contentious, intolerant of difference of opinion, and filled with a belligerent attitude towards the medical profession. Second, it illustrates what to me at least seems a very unfortunate lack of critical judgment in many physicians, a lack of knowledge of how to evaluate a therapeutic experiment, a lack of knowledge of the natural course of poliomyelitis and a reprehensible tendency, of which, however, physicians are not fully responsible, toward allowing premature publicity. It is hard to resist the fundamental American tendency to ride on the "band wagon," in medicine as in other fields.

I think that epidemics of these last two years have made it very clear that again our people have suffered great disappointment in a treatment at first highly praised. We should look back with criticism of ourselves as physicians for not having demanded that any experimental

therapeutic attempt be properly recorded and quantitated and that proper control cases be chosen for comparison, and also with some humility that the challenge of this nurse has been necessary to stimulate long-needed research in muscle function and a fresh evaluation of our own intrenched orthopedic habits by more critical clinical studies.

TRAUMATIC NEUROCIRCULATORY DISORDERS OF THE EXTREMITIES

J. Dewey Bisgard, M.D., Omaha, Nebraska

In THE AMERICAN JOURNAL OF SURGERY,
27;2;210
February, 1945

In both military and civilian practice there are encountered certain definite clinical entities which from the lack of definitive understanding have been designated post-traumatic neuro-vascular lesions of the extremities.

Sudeck's bone atrophy is seen not infrequently in association with fractures about the wrist joint but may follow relatively trivial and minor injuries.

*The treatment of post-traumatic neuro-vas*cular lesions varies with the individual case. The acute vascular contractures with impending gangrene are emergencies, demanding immediate efforts to relieve vascular spasm by means of *novocainization of the regional sympathetic* ganglia or periarterial sympathectomy. Heat should not be applied to these extremities.

Before treatment is undertaken in chronic cases a careful neurological and psychiatric study *should be made in an effort to exclude compensa*tion neuroses and hysteria. All doubtful cases, and there are many, should be looked upon as true causalgias and treated accordingly until a diagnostic therapeutic trial has proved them *otherwise. To dismiss them simply as psycho*genic does a great injustice to these sufferers.

Minor causalgias and particulary the bone *atrophy of Sudeck following fractures or other* injuries may be prevented by the early institution of physical therapy and once developed this form of therapy probably shortens the otherwise long period of recovery.

Because the patients in the more severe cases are likely to become addicted to morphine, every effort should be made to obtain early relief of *pain.*

ARTIFICIAL FEVER AND CHEMOTHERAPY IN EARLY SYPHILIS

H. Worley Kendell, M.D., Donald L. Rose, M.D., Elsie Miller, B.A. and Walter M. Simpson, M.D., Dayton, Ohio

In ARCHIVES OF PHYSICAL MEDICINE,
26;2;85
February, 1945

The clinical and serologic findings for 37 patients with early syphilis treated by one session of fever-chemotherapy are presented.

Quantitative serologic tests are an important prognostic guide in following the results of therapy.

Intensification of fever-chemotherapy as described increases complications during and after the treatment.

A ten hour session of artificially induced fever at 106° F. (rectal) combined with administration of 120 to 240 mg. of mapharsen and 4 grains of bismuth subsalicylate in oil (150 mg. of elemental bismuth) is not recommended at the present time as a routine for the treatment of early syphilis.

ARTIFICIAL RESPIRATION BY RIB TRACTION

R. Viswanathan, M.D. Lond., MRCP, TDD Lieut.-Colonel IAMC

In THE LANCET, No. 6339;238
February 24, 1945

If the patient is on a bed or on an operating-*table lying on his back, the operator stands at* the head end and places the palms of the hands on the lower part of the chest, the middle fingers being on the anterior axillary lines. The fingers are hooked round the lower costal margins on *both sides. The pull is made in an upward and* outward direction, thereby raising the anterior portions of the ribs as well as widening the lower costal arches. After a steady pull for 3 seconds the pull is released and the chest is *gently pressed downward and inward, while the* extended fingers exercise the same pressure on the abdomen. Doing this about 12-15 times a *minute brings about a respiratory exchange of* over 7000 c.cm. of air. In addition, the expansion of the chest and outward stretching of the diaphragm, owing to the widening of the lower costal arches, helps the venous return of the *blood.*

Industrial Health

Committee On Industrial Health — Frederick W. Slobe, Chm., 2024 South Western Ave., Chicago, Frank P. Hammond, H. A. Vonachen, R. I. Barickman, C. O. Sappington, Milton H. Kronenberg.

PLANS FOR CHICAGO REHABILITATION CENTER

Plans are underway for the development of a Rehabilitation Center project sponsored by the Committee on the Handicapped of the Council of Social Agencies which arranged a committee headed by Dr. Carl Peterson, Secretary of the Council of Industrial Health of the American Medical Association, and with members representing hospitals, medical schools, the Federal Government, the Visiting Nurses Association, the committees on Industrial Health of the Illinois Medical Society and the Chicago Medical Society, and various charitable and health agencies. Rehabilitation Centers are in successful operation in various cities and it is felt that there is need for such a Center in Chicago. The proposed Center will probably include a curative workshop, an adjustment workshop, and a sheltered workshop and will service both acute and chronic conditions. It will service both charity and pay patients referred to it by physicians, corporations and by local, state, and national agencies. This Center will doubtless be established independently without any identification with any particular hospital, thus promoting more free utilization by physicians. It will not duplicate existing services in hospitals because, although there are about 33 general hospitals in Chicago having a physical therapy department only a few have an occupational therapy department and, for the most part, vocational analysis and work adjustment are neglected. It is aimed that sound cooperative relationship be maintained with other community agencies and the medical profession. Care should be taken to keep referring agencies and physicians fully informed of the progress of their clients and patients. The work should be safeguarded by the employment of a consulting medical staff consisting of physicians from the different specialties with a full-time qualified physician in charge. The Center will probably have a general Advisory Committee including representatives of the professions concerned and interested lay and business people. The project should become partially self-supporting in time but funds will be required to inaugurate and to maintain it and the source of such funds has not yet been determined. The project is in the formative stage but with so worthy a project, it is hoped that it will meet with the success it merits.

INDUSTRIAL HEALTH EDUCATION PROJECT

Another project being developed in Chicago is that of a health education program in industry, the original sponsoring agencies being the Council of Social Agencies of Chicago, the Chicago Medical Society, and the Chicago Health Department. Cooperating agencies, it is hoped, will include the Educational Committee of the Illinois State Medical Society, the Municipal Tuberculosis Sanitarium, the Chicago Dental Society, the Chicago Society of Industrial Physicians and Surgeons, the Industrial Hygiene Division of the State Department of Public Health, the Industrial Nurses Section of the Illinois State Nurses Association, the Cook County Public Health Unit, and others. This proposed project is patterned after the Fort Greene Industrial Committee in Brooklyn, N. Y., the Fort Greene area being an industrial section of

Brooklyn comprising one of the districts of the New York City Department of Health. This has been in operation for a little over a year. A section of Chicago or Cook County may be selected or it may be developed as a city-wide activity and the name of the organization will be "The Chicago Industrial Health Committee." The purpose will be to provide industrial workers in participating industries with continuous and authentic health information on vital health problems and to promote the utilization of procedures, (such as Kahn tests, chest x-rays, vision testing, etc.) to be made available through cooperating health agencies as requested and available. It is not known as yet from which source the original financing will be arranged but it is self-supporting through payment by participating firms for the services they receive. Health education pamphlets will be issued, in-plant Labor Management Health Committees will be formed, posters and placards will be furnished, and film showings and short talks will be arranged; the initial impetus to the program in Chicago may well be the advocation of tuberculosis screening of entire plant personnel by means of small, portable x-ray units.

It is understood that treatment for non-occupational injuries and ailments will not be rendered and that cases of syphilis, tuberculosis, heart disease, etc., discovered during plant surveys will be referred to the family physicians.

SIGNS OF THE TIMES

Significant trends in the attitude of the public, the executive and administrative branches of our Government, and of medical minds, are becoming increasingly apparent. This may be a symptom of a social upheaval, concomitant with, or as an aftermath of the war. Only by a cognizance of the activities of the governmental agencies, organized labor groups, and the reaction of the public, can the medical profession develop measures to modify and guide these activities into those avenues which will best serve the public welfare. If communities, cities, and states develop facilities for the rehabilitation of the veteran, foster the development of certain pre-payment medical and surgical plans and hospitalization insurance, if the promulgation of the health of the industrial worker is furthered by broadened industrial health activities — we may be able to retain supervision of the development of many of these projects as local measures where, in general, they belong.

In the February 1945 issue of "Industrial Medicine" appear some interesting abstracts relating to some of these problems. These abstracts that are published herein are so included because of their news interest, with no inference that the Industrial Health Committee necessarily agrees or approves of all of the opinions expressed.*

INDUSTRIAL HEALTH X-RAYS

"A major feature of the Pennsylvania Tuberculosis Society program of the year was stimulation and promotion of active attention to the problem of tuberculosis in industry," according to the annual report of Arthur M. Dewees, Executive Secretary, presented at the fifty-second annual meeting in Harrisburg. "The objective has been the x-ray examination of workers and provision in industrial health services for constant and effective care regarding tuberculosis. Well above 100,000 persons have had chest x-rays in surveys conducted by voluntary tuberculosis organizations in Pennsylvania."—Wilkes-Barre Courier-Herald, January 4, 1945.

INDUSTRIAL HEALTH COMMITTEE

The University of Minnesota Medical School, Minneapolis, has announced its plan to create an industrial health and efficiency committee to assemble and coordinate the activities of the school in industrial medicine and to devise ways and means of making immediately available to industry discoveries and developments in this field. At a recent meeting at which Dr. Harold S. Diehl, dean of medical sciences at Minnesota, announced plans for the Mayo Memorial, consideration was given to the relationship and value of the memorial to the industries of the state, this point having been discussed at a previous meeting of the committee of founders of the memorial. The creation of the industrial health and efficiency committee was believed the best step in developing a coordinated program at the university to ensure a comprehensive and well regulated development of research teaching programs and other matters incidental to industrial health and medicine. It was proposed that the committee consist of the heads of the departments of the school of medicine most immediately concerned with the program.

UNION HEALTH HOME

The new $120,000 UAW-CIO Health Institute in the remodeled Edsel Ford home, 7930 E. Jefferson, was opened to the public January 18. Attending the ceremonies were Dr. Thomas Parran, Surgeon General of the U. S.; R. J. Thomas, UAW president;

*Industrial Medicine, February, 1945.

George F. Addes, UAW secretary-treasurer; Walter P. Reuther, UAW vice president, and other high ranking UAW officials. The Ford home, which was purchased in April, 1944, for $50,000, has been remodeled at a cost of $45,000 and new equipment costing $25,000 has been added. The institute program as outlined by Addes includes examinations for all workers with industrial health problems; group examinations from shops to aid in the discovery and prevention of industrial health hazards and the establishment of health and safety committees; health education for every worker and a personal service offering professional advice to workers with personal problems which affect their work and relationship with other people. Dr. Morris Raskin, who has been closely associated with the union for several years, has been appointed director of the institute, and Leslie Anderson, assistant to Addes, as director of the health and accident department.—Detroit Times, January 18, 1945.

HEALTH PROGRAM REPORT

Twenty-nine doctors, economists, administrators and representatives of organized labor have announced a new plan to insure good medical care for all Americans. CIO Research Director J. Raymond Walsh and Florence C. Thorne, of the AFL Research Department, helped draw it up. The plan proposes a national system of health insurance to which employees, employers and self-employed persons would be required by law to contribute in proportion to earning capacity. Low-income families would be provided for by supplementary taxation. Chief points of difference from the W-M-D Bill; Provision for a decentralized administration, with local units exercising autonomy under national standards; recognition of existing voluntary hospital and health insurance plans; and the determination of policy by groups in which both the public and the medical profession would be represented. The term "medical service" is used to cover hospital care as well as preventive, diagnostic, and treatment services. The report was presented as "a framework for improved national health legislation and for action by non-government bodies," rather than as a bill for congressional action. It was worked out by 13 doctors, staff members of the Rockefeller foundation and the U. S. Public Health Service, eight health insurance economists and eight administrators from government and private agencies, in addition to the labor representatives.—Northern California Union Health Committees' Newsletter, 2:1 January 3, 1945.

TEACHING INDUSTRIAL HEALTH

Those who are keeping posted on current trends will agree, no doubt, that industrial health and the general relations developing between medicine, labor and industry are of first rank importance. The subject needs a great deal of consideration by the medical profession. This is especially true with respect to medical education. Medical schools must prepare undergraduates with the basic elements of this phase of medical practice. Progress has been made in bringing this subject into the medical school curriculum, but not enough. A recent survey by the Council on Industrial Health of the A.M.A. shows that the average number of hours of required lectures on industrial health in the medical schools has increased 92% in the period 1939 to 1943 (from slightly more than five hours in 1939 to 9.6 hours in 1943). One school requires 64 lecture hours; some make no provision for teaching this subject. Only a few schools make provision for clinics, demonstrations and bedside teaching. Less than half report having field trips to industry. Ohio's three medical schools need to give this question more attention than at present. The College of Medicine, Ohio State University, requires 11 lecture hours in industrial medicine — above the average for all schools but meager in comparison to some schools. The University of Cincinnati College of Medicine requires eight lecture hours, and Western Reserve University School of Medicine, three lecture hours, plus three hours of clinics and demonstrations and two field trips. Correction of deficiencies in the time devoted to teaching industrial health is something which should be taken up by most medical schools as soon as feasible.—Ohio State Med. J., January, 1945.

SPECIFIC GROUP PROBLEMS

We will see a great expansion of the fight that the health of the individual in industry is important in the next few years. Industry is developing itself into not only a means of production, but also as a social institution, and a medical department in industry is more cognizant of the industrial hazards than a medical department that has no knowledge of the industry in which the man works. In other words, a group of people working in an industry are developing into a group having specific medical problems that can best be handled by a medical department cooperating with the employer.—From an address by Dr. R. E. S. Young, Medical Director, Curtiss-Wright, Columbus, at All-Ohio Safety Congress.

THE SIDES ARE HIGHER

The people should heed the wide-spread editorial criticism of the Wagner-Murray bill, now before Congress, to drastically increase social security taxes and bring the medical profession under total domination of government. One editor, in commenting on the bill, declares it "would destroy the private practices of medicine in the United States. It would open a road which would lead straight to a monstrously expanded Federal bureaucracy of such power that America would inevitably be transformed into a totalitaran state. . . . Frankly, I am less concerned with the welfare of the physicians than I am with the tremendous stride toward the further regimentation of American life which will be taken if this bill is passed. Legitimate business has already been put in a rut. It is proposed to put the medical profession in a rut. Next, one profession after another will be put in a rut. And the only difference between a rut and a

grave is that the sides of the grave are higher. But in time the rut will be deep enough."—"Item of Interest," in Weekly Bulletin, St. Louis Medical Society, January 12, 1945.

THE SHAPE OF THINGS TO COME

A digest of Albert Deutch's "Dilemma in Veterans' Administration," published in the St. Louis Star-Times, January 10, 1944. Mr. Deutch, a layman, has made an extensive study of the workings of the Veteran Administration and has come to some definite and interesting conclusions. He states that it is the biggest Life Insurance Company in the world and the world's largest Medical Care System with the possible exception of the Soviet Union. The defects, in his mind, may be traceable to faulty and inadequate legislation, administrative flaws, and to a combination of both. The following are the pertinent factors in the present administration of the veteran affairs. We quote: "(1) Dollar-honest but incompetent executives. (2) A colossal bureaucracy — tremendously expanded by the G. I. Bill of Rights and other recent veteran legislation — stricken with creeping paralysis in the face of a monumental task. (3) The tangling of human destiny in an excessive mass of red tape. (4) A traditionally isolationist attitude within the Veterans' Administration that has hampered cooperation with other agencies, fostered an unhealthy separation between veterans and non-veterans, and kept veterans' institutions physically, socially and scientifically removed from community life. (5) A medieval attitude toward medicine which discourages good doctors from going into Veterans' Administration facilities, accepts new curative drugs and devices belatedly and reluctantly, puts a damper on medical research that keeps a medical staff alert and advanced, and checks mutually helpful cooperation with medical groups and facilities outside the veteran field. (6) Undue kowtowing to politicians and veteran pressure organizations in making appointments, thus diluting the quality of personnel and resulting in lower standards of care and treatment. (7) Sloppy methods of pension rating, especially in the case of psychoneurotics, which breeds a disease known to medical men as 'compensationitis,' 'pensionitis,' or 'pension neurosis.' (8) Extravagant waste of badly-needed medical skills by requiring VA doctors to spend much of their time in paper work that should be done by clerical aids, thus freeing physicians for active therapeutic work on veterans. (9) Excessive stress on the money side of veteran help — pension rating, insurance, etc. — to the detriment of medical and other rehabilitative efforts." This is a sample of how socialized medicine probably would be administered. Let us redouble our efforts in the prevention of regimentation and bureaucratic rule in America.—Editorial by EAGY, in Weekly Bulletin of the St. Louis Medical Society, January 26, 1945.

CAUTION NEEDED IN ADMINISTRATION OF THIOURACIL FOR TOXIC GOITER

Physicians must exercise caution in the administration of thiouracil for treatment of toxic goiter until satisfactory methods of preventing or controlling the toxic properties of the drug are developed, Samuel L. Gargill, M.D., and Mark Falcon Lesses, M.D., Boston, advise in *The Journal of the American Medical Association* for April 7. Thiouracil is a valuable drug for the treatment of thyrotoxicosis, but it is also an unpredictably toxic drug which may produce serious and uncontrollable effects, especially on the bone marrow and liver.

"As one reviews the toxic manifestations of thiouracil," the two doctors report, "a noteworthy analogy to the sulfonamides emerges. The sulfonamides possess some antithyroidal and goitrogenic properties but to a lesser extent than thiourea derivatives. In the development of granulocytopenia and agranulocytosis dermatitis, drug fever, jaundice and probably anemia, there is much parallelism. Both are sensitizing drugs, and this is the likely explanation of their similar toxic effects, since they are quite unrelated in chemical structure.

"Thiouracil is a potent agent in the treatment of thyrotoxicosis, but it has dangerous toxic effects which so far have proved unavoidable and unpredictable, thus seriously limiting the use of the drug. . . ."

The toxic effect of thiouracil on the bone marrow is characterized by the disappearance of mature granulocytes. "As evidence of this destruction, one may note the large numbers of disintegrating forms seen in the bone marrow smears. It is, of course, also possible that similar destruction of granulocytes may have occurred in the peripheral blood, adding to the rapidity of onset of the agranulocytosis. . . ."

News of the State

PERSONALS · COMING EVENTS · MARRIAGES · DEATHS

★ WAR SERVICE ACTIVITIES ★

COOK COUNTY

Lieut. Col. Manuel E. Lichtenstein, formerly Chicago, was recently awarded the Bronze Star. The citation indicated that "as chief of surgical service he efficiently organized the service and conspicuously directed its functions with outstanding professional skill." He also "demonstrated unusual ability as a teacher and was responsible for the superior training results attained." Dr. Lichtenstein graduated from Rush Medical College, Chicago, in 1925 and entered the service Oct. 15, 1942. He is now serving with the Michael Reese Hospital unit with the 5th Army in Italy.

The Bronze Star was recently awarded to Capt. Ernest D. Geever, formerly of Chicago. The citation read "for distinguishing himself by meritorious service in connection with military operations against an enemy of the United States from Dec. 6, 1944 to Jan. 20, 1945 in Germany and Belgium. As battalion surgeon, Lieutenant Geever performed his duties in a superior manner. Without hesitation and without an assistant, under the most adverse conditions of enemy action, weather and fatigue, he worked to provide the best medical care of the wounded. The professional skill, humanity and tireless devotion to duty displayed by this officer are in keeping with the finest traditions of the armed forces of the United States." Since the award was made, Dr. Greever has been promoted to captain. He graduated from the University of Illinois College of Medicine, Chicago, in 1943 and entered the service in January 1944.

Word has recently been received from the United States military mission in Moscow through the adjutant general's office that Capt. Frederick Marks, formerly of Chicago, has been released from a German prison camp by the Russian army. He was captured at the Anzio beachhead May 26, 1944. Dr. Marks graduated from Northwestern University Medical School, Chicago, in 1941 and entered the service in April 1943.

Major Joseph M. Greene, Chicago surgeon, was recently awarded the Purple Heart. Major Greene, a member of the medical staff of Northwestern University, who now is somewhere in Germany, is attached to the 105th Evacuation Hospital which was bombed by enemy aircraft last New Year's Eve.

The Bronze medal for bravery and efficiency was recently awarded to Capt. F. C. Winskunas, formerly of Chicago. Dr. Wiskunas graduated from Loyola University School of Medicine, Chicago, in 1932, and entered the service Oct. 21, 1942.

Jerome J. Burke has recently been promoted from Lieutenant (SG) to Lieut. Commander and is now stationed at Seattle, Washington.

Lieut. Leo B. Lifchultz, Medical Detachment 32nd Infantry, has just returned from Saipan on a medical furlough.

Lt. Col. W. J. Vynalek, Comm. Surgeon of the 108th General Hospital in Paris, France, is a patient in Vaughan General Hospital.

Captain Howard McNally, Flight Surgeon assigned to England, made the trip from England to Chicago in 21 hours.

Colonel Durand Smith, Commanding Officer of the 108th Medical Battalion, gave the G.I. "Little Mothers' Club" permission to adopt one-year-old Little Annie. Little Annie has four foster "mothers" who, before the war, were a barber, a butcher, a restaurant manager and a supply man for a pinball machine manufacturer, who cared for her wants between shell bursts.

Sidney James McLeod of Chicago has been recently promoted from Major to Lt. Colonel in the Army Medical Corps.

Lt. Colonel John H. Gilmore, formerly of Chicago is Chief of the x-ray services at William Beaumont General Hospital, El Paso, Tex. He was radiologist to Illinois Masonic Hospital and the Illinois Eye, Ear, Nose & Throat Infirmary before entering the army.

Colonel Carl Steinhoff, USA, of Chicago was a recent visitor at a meeting of the Chicago Medical Society.

Lt. Col. Edwin M. Miller, Chief of surgical service General Hospital 13 in New Guinea, is a patient in Vaughan General Hospital.

Major Stanley E. Lawton has been made Chief of the surgical service of General Hospital 13, replacing Lt. Col. Miller.

Major Francis H. Strauss of General Hospital 13 in New Guinea, has returned to this country and is in Chicago.

Major George W. Stuppy has been detached from General Hospital 13 and is now serving as Chief of the medical service of the 80th General Hospital.

Major Richard Gilchrist has been made Chief of the surgical service of a Station Hospital in New Guinea.

Major H. Ivan Sippy has been appointed Chief of the Medical service of a Station Hospital in New Guinea.

Captain Stanton A. Friedberg and Captain John E. Tysell have been detached from General Hospital 13 and are serving in the Philippines.

Captain Cecil C. Draa has just returned to the Pacific after a leave.

Cmdr. Fred Shapiro, U.S.N.R., of 4507 N. Beacon st., was awarded the Legion of Merit at the U. S. Naval Hospital in Seattle, where he now is staff surgeon, for serving as marine regimental surgeon during the Tarawa, Gilbert Islands, Saipan and Tinian operations.

A graduate of the University of Illinois medical school, he was on the faculty of Rush Medical College for 10 years.

During the Saipan invasion, the citation read, "his skill as a surgeon contributed greatly to the saving of many lives. During this period he personally took care of 262 compound fractures, displaying outstanding skill and untiring effort in the care of the wounded."

Reno Rosi, medical officer of a hospital in Italy has been promoted to major. He has been overseas more than 26 months and during the winter of 1943-44 served with the typhus commission in Naples. Major Rosi graduated from the University of Chicago and Northwestern University. Before entering the service, more than three years ago, he was attending physician at Wesley Memorial Hospital, associate attending physician at Cook County Hospital and an instructor at Northwestern University.

Captain Bronislava Z. Reznick of Chicago recently wrote the Editor of the Journal, "The four journals which I have received recently were much appreciated and I am going to contribute them to our library. Our 239th hospital is located in France. We received excellent rating following the official inspection."

The following army promotions of Illinois physicians has just been announced: From Lt. Colonel to Colonel, Gilbert H. Marquardt; from Major to Lt. Colonel, William Carl Beck, Richard C. Boyer, James C. Conte, Jr. all of Chicago, James J. Callahan of Oak Park and James Parkes Grier of Evanston.

The greatest person in the world is the wounded American fighting man with his unfailing sense of humor, Col. Leo P. A. Sweeney, 45, of 9715 Winston Ave., reports. The colonel, an eye, ear, nose and throat specialist in Chicago before entering the army four years ago, was chief surgeon for the peninsular base section of the army, with headquarters in Naples, Italy, before he returned home Sunday for a period of detached service.

Next in Col. Sweeney's regard are the army nurses. "Those women do a grand job," he said, "and there aren't enough of them." He also paid tribute to his wife, Elaine. "The women at home have a weary time," he declared, "and my wife has done wonderfully, caring for our three children and doing volunteer war work." The Sweeney children are Lee, 17, James, 14, and Lois, 12.

Col. Sweeney has two bronze stars for campaigns at Naples and Anzio. He also wears a ribbon signifying the order of the crown of Italy, which he received for service to Italian civilians and military personnel.

Maj. Charles A. Serbst, 1557 Olive Ave., Chicago, was commander of a surgical unit at Wiltz, Luxemberg, southeast of Bastogne, Belgium, when that town was overrun by the Germans last Dec. 20 in the Ardennes breakthru. He had refused to abandon several American soldiers on whom he had just operated and by that decision

probably saved his life. Those who tried to get out were caught in enemy cross fire and most were killed.

Serbst was taken prisoner. His story from then on, until he and three other American officers escaped March 27 from the Hammelburg oflag (prisoner of war camp for officers) near Wuerzburg, is a harrowing tale of forced marches and suffering from hunger, cold and of cramped, filthy quarters.

Troops of the Chinese 1st army, with which this mobile American unit is attached, call him "Mr. Mercy Man." He has worked hard for many months. His record is like many others in American hospital teams hidden in the mountains and rivers of Burma.

"Mr. Mercy Man" is Maj. Francis J. Sazama, 3801 S. 59th Ave., Cicero, Ill. Commanding officer of the 58th mobile surgical hospital, Sazama flew into Myitkyina in support of American and Chinese troops early in June, 1944, when allied troops were ringing that Jap stronghold.

Since then Sazama has been walking thru jungle trails that never seem to end. He led his unit along the advance flanks of the American trained and equipped Chinese army from Myitkyina to Lashio and toward the Salween river.

It's the work of Sazama and those under him that earned him the name of "Mr. Mercy Man." He told how more than 35 major operations were performed daily by his team of four doctors; how they would dig steps over sheer cliffs into the mountainsides so horses and mules could make the grade, and how men carried their full field kit on their backs besides medical supplies and surgical instruments.

Skilled surgery has resulted in a 50 per cent mortality reduction from abdominal wounds in World War II. as compared with World War I., Maj. George B. Sanders, assistant chief of medical service at the Vaughan General hospital, told a clinic at the hospital.

Blood plasma and the new "miracle" drugs, penicillin and sulfa, were given secondary rating as "useful adjuncts" by Maj. Sanders.

Mortality in wounds of the colon, once 60 per cent, has been reduced to 30 per cent, it was brought out.

Members of the Chicago Surgical society, who hold meetings in 10 different hospitals yearly, participated in the clinic.

In former wars men survived, only to wish they had died on the battlefield. They were the mutilated men, who lived out their hopeless lives in hospitals, institutions — any place where they could avoid the stares of their fellow men.

Now the shattered faces and bodies of such soldiers are being rebuilt and they are going back to their families, normal men. A Chicago surgeon, whose skillful hands formerly performed delicate and expensive operations at many Chicago hospitals, is now working 8 to 12 hours a day, six days a week, at Northington General hospital here, repairing the faces and bodies of boys who were maimed by enemy gunfire.

This surgeon is Maj. John Francis Pick, chief of plastic surgery at Northington, whose home is at 1420 Lake Shore Dr. Since he entered the army Feb. 17, 1943, he has performed more than 2,000 operations. He has been stationed since last September at Northington, one of eight army general hospitals set aside for plastic surgery.

Under the strain of unceasing work in the operating room, Maj. Pick's dark hair has turned gray, but his tall, slender figure is as erect and lithe as in the days when he was a well known polo player in Chicago. He calls his patients by their first names, and they talk to him as they would to a father.

Maj. Pick denies he and his staff work miracles, but his patients, who pose for pictures before and after surgical treatment, think differently. They are living evidence of what can be done by plastic surgery, and they quickly drive away the despair of disfigured men newly arrived from the battle fronts.

CHAMPAIGN COUNTY

Major J. G. Gillespie of Urbana has been transferred from Yale University to the Surgeon General's Office in Washington, D. C.

DE WITT COUNTY

A letter from Lt. Col. H. L. Meltzer in Honolulu informs us he is still hard at work. He is now in charge of preventative medicine for a large command. He and his setup consisting of medical men, sanitary engineers, bacteriologist and industrial hygiene workers are kept pretty busy on communicable disease control, sanitary engineering, control of disease bearing insects and the like. He evidently has considerable territory to cover for he stated that he had traveled 2200 miles by plane one day in his work. With this experience he might make us a good man for city physician when he returns to Clinton. Evidently he still enjoys horseback riding for he sent along a snap of himself and an old plug which we presume he borrowed from some milk wagon delivery.

GRUNDY COUNTY

Hyman S. Gordon of Coal City was recently promoted from Major to Lt. Colonel in the U. S. Army, Medical Corps.

KNOX COUNTY

Aloys George Ansprenger, M.D., a very capable radiologist practicing in Galesburg, and a member of the society has recently been commissioned a Lt. Commander in the Naval Reserve and will report at Great Lakes on May 5. He is the first German-born American citizen to be commissioned by the Navy, as they waived their 10 year citizenship requirement in his case.

LA SALLE COUNTY

Dr. Clifford L. Carter, 38, Ottawa physician and surgeon, who left here Oct. 1, 1942, to enter the U. S. army medical corps, has been promoted from captain to major in eastern France. Maj. Carter has been overseas for the past year, having served in Oran, Africa, Madaloni, Italy, near Naples and then in France.

He enlisted in July, 1942, when the University of Illinois evacuation hospital unit was being organized. Before going overseas Maj. Carter was stationed at Camp Breckenridge, Ky., in Tennesee, at Elkins, W. Va., and Ft. Devins, Md.

MADISON COUNTY

Dr. W. W. Billings of Alton, filed a formal request with the county board of supervisors for a leave of absence from the duties of coroner of Madison county and suggests the appointment of Fred Pieper of Madison as acting coroner.

Dr. Billings has been commissioned as a lieutenant commander in the navy and ordered to report at the Great Lakes Naval Training Station on April 23rd. He served three months in the army in World War I, going in shortly before the signing of the armistice. He has a son, Corp. Edgar Billings, who is in the Air Corps and is serving as a radio operator on a B-25 bomber in the Pacific.

Dr. Billings was elected last November to his third term as coroner.

PEORIA COUNTY

The Navy Cross was recently presented to Lieut. (jg) Robert Thomas Browne, formerly of Peoria, Ill., "for extraordinary heroism while attached to the U. S. S. *Johnston* in action against enemy Japanese forces off the Island of Samar during the second battle of the Philippines on Oct. 25, 1944. Acting with cool initiative when the abandon ship order was given, Lieutenant, Junior Grade, Browne remained on board the *Johnston* supplying injured men with life jackets, assisting to evacuate them from the stricken vessel and ministering to the wounded in the face of terrific salvos from hostile gun batteries. A calm and courageous leader, Lieutenant, Junior Grade, Browne served as an inspiring example of fortitude and loyalty throughout the bitter engagement with powerful units of the Japanese fleet. By his gallant spirit of self sacrifice he rendered valiant service to his shipmates at extreme risk to his own life and upheld the highest traditions of the United States Naval Service." Dr. Browne graduated from the University of Illinois College of Medicine in 1942 and entered the service July 10, 1943.

The past month has seen the return of several Peoria doctors to the U. S. A. from battle fields abroad. They are recuperating from various ailments and are enjoying or have the pleasure of being home for awhile at least.

Dick Martin has returned from the Loyola Unit which was located near Paris. That unit arrived in France soon after the breakthrough and has been active since. Dick didn't stay in Peoria very long after his return but rumor says he traveled South for recuperation. He is now at the Mayo General Hospital at Galesburg.

Wally King who was with the 3rd Surg. Gr. in France and Belgium was transferred from Paris to England as a patient and finally arrived in this country in January. He enjoyed a 15 day leave in Peoria and from here he went to the Schick General Hospital at Clinton, Iowa to carry out his treatments. He expects some change in his assignment after his release from the hospital.

George Borin has been in a rest camp in California and has recently had a leave in Peoria. George was with an anti-aircraft unit in France and found himself up in the front lines when the unit was used for purposes other than originally planned. We had the pleasure of seeing him during his Peoria stay but he has now returned to California.

"Mac" McCuskey has been transferred from Camp Roberts, Cal., to a camp near Nashville, Tenn.

Howard Miller has left his southern camp and probably has an A.P.O. number by this time.

Jim Sours has left his post at Great Lakes for a period of schooling in California. He did not know how long the training would last but expects a different assignment after it is over which will take him to the far reaches of the Pacific.

Wilbur Bowen has spent considerable time with the 7th Army in France but has recently moved to another unit farther North.

Mac McQuiston has also made another move and when last heard from was stationed at the O'Reilly General Hospital at Springfield, Missouri.

Nevelin has received a Medical discharge from the Army and is now taking a residency in Medicine.

Fred Endres was promoted to the rank of Lt. Col. The promotion was received in the field in France where he has been located since shortly after D-Day. Fred has been in Europe over three years. Congratulations on your promotion, Fred.

Elliott Burt and Frank Green were in the Philippines, arriving there very soon after the invasion of Lingayen Gulf.

VERMILION COUNTY

Danville's highest-ranking medical officer, Col. Holland Williamson, has assumed command of the Army Convalescent Hospital at Camp Edwards, Mass.

Col. Williamson, a veteran of 30 months in the Pacific theater, was commanding officer of the U. S. Army General Hospital in New Guinea. He returned to this country the first of the year.

A practicing physician for 10 years prior to entering the Army in 1941, Col. Williamson is married and has two children.

GENERAL

ADAMS COUNTY

Adams is the second county in Illinois to appoint a County Board of Health. At the last general election held November, 1944, Adams and DuPage counties voted to tax themselves for the support of a county health department, under the Searcy-Clabaugh Law.

CARROLL COUNTY

The Frances Shimer College, Mount Carroll, has received a bequest from the late Dr. Blanche M. Haines, Three Rivers, Mich., of $20,000 to set up the George R. Moore Memorial Fund to be used to improve and promote the teaching of sciences. Dr. Haines graduated at the Woman's Medical College, Chicago, in 1886 and the fund honors her father, who died in 1910.

COOK COUNTY

Andrew C. Ivy addressed the Iowa and Illinois Central District Medical Association at Davenport, Iowa on May 24th. His subject was "Some Contributions of Medicine to Survival on a Raft at Sea."

An oil painting of Dr. Ludvig Hektoen, 82, internationally noted Chicago pathologist, was presented to the Institute of Medicine of Chicago, 82 E. Randolph St. The painting by Carl Tolpo, a Chicago artist, is the gift of the Institute's fellows. Dr. Hektoen, who helped found the organization, is now honorary chairman of its board of governors.

Dr. Warren H. Cole, professor and head of the department of surgery, University of Illinois College of Medicine, has been appointed to serve also as associate dean of the college of medicine. Dr. Cole, who has been with the University of Illinois since 1936, will in his new capacity assist Dr. Raymond B. Allen as dean of the college of medicine.

Dr. Josiah Moore, 6937 Bennett Ave., president of the Chicago Medical Society, will receive an honorary doctor of laws degree from Montana State University on June 4. Dr. Moore, treasurer of the American Medical Association, will deliver the commencement address and will be awarded the degree for a "distinguished record in pathology."

Karl Paul Link, Ph.D., professor of biochemistry, Wisconsin Agricultural Experiment Station, Madison, will deliver the second WilliamHamlin Wilder Memorial Lecture of the Institute of Medicine of Chicago at the Palmer House, May 25. His subject will be "The Anticoagulant Dicumarol."

Mount Sinai Hospital has established a blood bank under the direction of its pathologist and director of laboratories, Dr. Israel Davidsohn. The bank was established primarily to facilitate the blood transfusion service to patients at Mount Sinai Hospital. As the bank makes progress, it is hoped that blood may be made available in modest amounts to patients outside the hospital.

Dr. George W. Wakerlin, professor and head of the department of physiology, University of Illinois College of Medicine, has been appointed to serve also as assistant dean in charge of teaching and research at the Rush-Presbyterian Hospital, division of the University of Illinois College of Medicine. Dr. Wakerkin will work with the administration of the hospital, the Rush faculty, and the college of medicine in developing a comprehensive program of undergraduate and graduate medical education and research at Presbyterian Hospital and the Central Free Dispensary. A number of appointments to research positions in the medical sciences are to be made as part of this program.

A grant of $175,000 to the University of Chicago for research in pediatrics from the estate of the late Dr. Walter H. O. Hoffmann was announced on March 28. The gift brings to $832,722 the amount for support of teaching and research into the care and nurture of children since Dec. 15, 1944, newspapers report. Other gifts to the university include $25,940 from the general education board for verbal tests in I. Q.,

$20,000 from the Sonia Shankman Foundation for scholarships and research in the university's orthogenic school, two of $15,000 for cancer research from the Albert and Mary Lasker Foundation and the Frances and Sidney Brody charitable fund, $15,000 from Mrs. R. S. Maguire for university support, $10,000 from T. Philip Swift for the department of medicine and $10,000 from the E. J. Brach fund for general research.

Among those on the annual postgraduate program of the University of Michigan Medical School are Dr. Georgiana D. Theobald, pathologist of the Illinois Eye and Ear Infirmary, as guest lecturer in ophthalmology; Dr. Elizabeth C. Crosby, professor of anatomy, University of Illinois; and Dr. Ruth C. Wanstrom, professor of pathology, University of Michigan, who will also lecture on ophthalmology.

An inheritance tax appraisement listing net assets of $1,540,827 in the estate of the late Dr. Arthur Dean Bevan was submitted April 10 to County Judge Perry L. Person of Lake County. Presbyterian Hospital, where Dr. Bevan was chief surgeon for many years, will receive $975,247, Rush Medical College $113,884 and Lake Forest Hospital, Lake Forest, Ill., $25,000, it was reported.

A fiftieth anniversary campaign for Chicago Lying-In Hospital of the University of Chicago is being undertaken by its board of directors. Mrs. Kellogg Fairbanks is chairman of the committee in charge of fund raising, with offices at room 718, People's Gas Building, 122 South Michigan Avenue, Chicago 3. Mrs. Josephine Patterson Reeve will handle publicity pertaining to the campaign through this office.

Dr. Louis G. Hoffman, a member of the faculty of Loyola University School of Medicine since 1934, has been appointed acting chairman of the department of ophthalmology. He succeeds the late Dr. Carl. F. Schaub. Dr. Hoffman graduated at Northwestern University Medical School in 1910. Dr. Samuel Salinger, professor of otorhinolaryngology and a member of the faculty since 1917, has been named acting chairman of the department of otorhinolaryngology, succeeding Dr. George T. Jordan, who is now professor emeritus.

DE KALB COUNTY

At a joint meeting of the DeKalb County Medical Society and the DeKalb County Tuberculosis Association held on April 5th with more than two hundred present, Dr. J. S. Rankin of DeKalb was presented the gold pin and certificate in recognition of his 50 years in the practice of medicine. Lawrence J. Hughes, Councilor of Elgin, made the presentation. The speaker of the evening was Dr. A. A. Pleyete of Milwaukee, Wisconsin, who was introduced by Dr. L. L. Collins, Medical Director of the DeKalb County Sanatorium, of Ottawa.

Representatives from every township in the county were present to honor Dr. Rankin.

DE WITT COUNTY

The Clinton physicians are taking part in the annual P. T. A. Summer Round Up for the preschool children May 15th. They are also following their annual custom of putting on an immunization campaign during the months of May, June and July.

HEARD AT THE MEDICAL MEETING THE OTHER DAY. 1st member: Well, Dr., how are you spending your time these days?

2nd member: About as follows: 30% at the hospital and calling on my patients, 40% in my office waiting on patients, 30% reading, sleeping and eating and 20%making out reports, old age pension slips, insurance inquiries and such.

1st member: But that adds up to 120%.

2nd member: Doctor, you're telling me.

We have begun to notice evidences of Victory Gardenitis among some of our members — Symtoms, walking slightly stooped and complaining of backache.

We will miss the pleasant associations usually experienced at the annual state medical meeting this year but that is just another of the war casualties physicians are experiencing.

DU PAGE COUNTY

Effective March 21, 1945, Dr. Sidney Franklin was appointed health officer of the DuPage County Health Department, succeeding Dr. Joseph A. Markley. Dr. Franklin is a Past Assistant Surgeon (R) of the U. S. Public Health service. He received his medical degree from Yale University and the Master of Public Health degree from the DeLamar Institute of Public Health of Columbia University. Dr. Franklin has served as county health officer in both Kentucky and Michigan.

FAYETTE COUNTY

At a recent meeting of the Fayette County Tuberculosis Association, Dr. E. J. Bost, Vandalia, was re-elected President of the Association.

HANCOCK COUNTY

Dr. Charles A. Runyon, Carthage, recently received a wrist watch as a gift of the Art Baker Hollywood program "Never Too Old," which is dedicated to older professional men and women who are continuing their services to the public.

Dr. Runyon, who graduated at the College of Physicians and Surgeons, Keokuk, Iowa, in 1884, has been practicing in Elvaston and Carthage nearly sixty-two years. The program which recognized him was heard over MBS February 16.

LIVINGSTON COUNTY

E. P. Coleman, M.D., Canton, President, Illinois State Medical Society, spoke before the Livingston County Medical Society at a dinner meeting March 1, at the Livingston County Sanatorium, Pontiac, on the subject "Acute Abdominal Pathology." Following this, there was an open discussion led by Dr. Coleman on the trends of medical legislation.

The County Medical Auxiliary were guests. Others present were the District Health Officer, Col. W. A. Morse, retired, Odell, and Miss Maude Ramsay, R.N., Iroquois County Tuberculosis Nurse, Watseka, Illinois.

MARION COUNTY

Robert K. Campbell and J. A. Stocker of Springfield presented *the program at the May* 17th meeting of Marion County Medical Society held in Centralia.

MERCER COUNTY

Dr. C. M. Murrell of Sherrard was named vice president of the Mercer *county medical society* at the annual meeting held in Aledo. Dr. Nellie Marsh of Aledo was named president and Dr. V. A. McClanahan of Aledo was reelected secretary-treasurer.

McDONOUGH COUNTY

Dr. J. T. Googe has been appointed health officer of the McDonough-Fulton County Health Department, succeeding the late Dr. C. P. McRaven. A Surgeon (R) in the U. S. Public *Health Service, Dr. Googe has had more than* 25 years of experience in the public health field. *In addition to local health work in Mississippi,* Nebraska and Florida, he served as Quarantine *Officer at Ellis Island. Dr. Googe assumed his* new duties March 28.

SANGAMON COUNTY

Officers were elected at the recent Annual Meeting of the Public Health Nursing and Tu*berculosis Association* of Sangamon County. Those chosen to serve for the coming year are: *Dr. C. F. Deatherage, President; Jay Parr,* Vice-President; Dr. George Stericker, Vice-President.

ST. CLAIR COUNTY

In an attempt to stamp out rabies in East St. Louis an ordinance was enacted by the city council to provide that in the future all applicants for dog licenses must produce from the city clerk a certificate *showing that the dog has been* vaccinated against rabies.

WINNEBAGO COUNTY

Dr. Herman L. Kretschmer, President of the American Medical Association, addressed the *Winnebago County Medical Society, Rockford,* March 13, on "Problems in Kidney Surgery" *and the Aux Plaines Branch of the Chicago Med*ical Society, March 23, on "Differential Diagnosis in *Renal Disease."*

An Industrial Health Conference was held in Rockford, Illinois, on May 15th, at the Faust Hotel, *sponsored by the Winnebago County* Medical Society, the Rockford Industrial Nurses Association, and the Rockford Chamber of Commerce. The speakers and their respective subjects are as follows:

Dr. Edward C. Holmblad, Managing Director, American Association of Industrial *Physicians* and Surgeons, Chicago, Ill. Subject: "Industry and the Physician."

Mr. H. E. Hewitt, General Superintendent, Visking Corporation, Chicago, Illinois. Subject: *"Industrial Health* and Business Economics."

Mr. Frank Peregrine, Attorney, Chicago, Il*linois. Subject: "Post-War Medico-Legal Prob*lems."

WHITE COUNTY

*The White County Medical Society at a meet*ing in Carmi on February 28, 1945, was ad*dressed by Dr. Max Hirshfelder of Centralia on* the subject of "New Developments in Ophthal*mology of Value to the General Practitioner."*

The following officers were elected for 1945:

Dr. C. J. Rosenberg, President
Dr. J. Z. Stanley, Vice-President
Dr. L. R. Medoff, Secretary-Treasurer

VERMILION COUNTY

James H. Hutton will give the address at the commencement *exercises of Lake View Hos*pital, Danville on May 21st.

WARREN COUNTY

Mrs. Myra Tubbs Ricketts of Kirkwood, widow of Doctor Howard Ricketts, has recently made *a substantial gift for the further* development of the medical library of the Warren County Med*ical Society. Now occupying the "Doctor's* Room" on the third floor of the Monmouth Hos*pital, provided through the board of directors,* the library has been in operation for a number of months but *Mrs. Ricketts' substantial gift,* from which the income will be available, has permitted the purchase of new furniture for the room and the further expansion of the list of

periodicals now available for reference use. Delivery is expected by early summer on the newly selected furnishings. The library makes it possible for the local physicians to keep in touch with latest developments as reported in the current literature of medicine, and it is already becoming regarded as one of the finest of its kind in the middle west.

DEATHS

JAMES ALFRED BOYER, retired, Carmi; Barnes Medical College, St. Louis, Mo., 1899. Was veteran of World War I. Had practiced medicine in Carmi since 1904. Died, aged 72, March 22nd.

ALBERT W. BOUSEMAN, Fountain Green; Barnes Medical College, St. Louis, Mo., 1910. Had practiced medicine in Fountain Green since graduation. Died of a heart attack April 15th, aged 64.

BENJAMIN HARRISON BREAKSTONE, Chicago; Rush Medical College, 1899. At time of death, was surgeon for Peoples' Hospital, consulting gynecologist at Douglas Park Hospital, attending surgeon at Montrose, Northern and Burnside Hospitals. Died of a heart attack April 23rd, at the age of 68.

VICTOR M. BRIAN, Lawrenceville; George Washington University School of Medicine, D. C., 1917. Was physician for Texaco Oil Company in Lawrenceville. Died suddenly March 27th at the age of 54.

CHARLES E. COLEMAN, Belleville; Bennet College of Eclectic Medicine and Surgery, Chicago, 1914. Had practiced medicine for several years in Benld, moved to Texas, and then located in Belleville. Died suddenly of a heart attack April 8th at the age of 73.

JOHN F. DAVIS, Chicago; University of Illinois College of Physicians and Surgeons, 1910. Was veteran of World War I; surgeon for Illinois Masonic Hospital and for the Rapid Transit Lines and for several industrial plants; was Cubs' club physician for 25 years. Died following a heart attack in April at the age of 69 years.

FREDERICK DETLEFSON, Chicago; University of Berlin, Germany, 1890. Died April 5 at the age of 84.

CARL GOTTFRIED JOHNSON, Galesburg, Long Island College of Medicine, 1892. In 1943 was awarded the Fifty Year Certificate of the Illinois State Medical Society. Died of a heart attack March 20th at the age of 80.

GORDON CLARENCE MCGARY, Chicago; Chicago Medical School, 1936. Served 14 months in World War II. Died of a heart attack March 24th at the age of 35.

IDA B. PUTNAM, Chicago; Hering Medical College and Hospital, 1897. Had lived in Chicago 75 years. Died in her home, April 11th at the age of 80.

HARRY PARSONS, Chicago; Hahnemann Medical College, 1880. Was one of the first physicians in Ravenswood. Died April 27 at the age of 86.

ROBERT R. SNIVELY, Chicago; University of Illinois College of Medicine, 1939. On staff of Wesley Memorial Hospital. Died April 19th, aged 32.

PAUL E. SUNDWALL, Waukegan; Chicago Medical School, 1925. Was county physician from 1938 to 1941 and following year was resident physician in the Lake County General Hospital. Died of a heart attack April 27, at the age of 57.

ALAN RICHARD WELCH, Lewistown; St. Louis University School of Medicine, 1914. Died March 31 at the age of 54.

CAPT. LEROY W. YOLTON, resident of Bloomington until he entered the army in 1942; Rush Medical College, 1931. His military service included Chicago, Hawaii, New Guinea and Leyte before going to Luzon where he was killed on February 3rd at the age of 45.

P. R. N.

The Jocular Jingles of C. G. F.

by

Charles G. Farnum M. D.
Peoria, Ill.

THE SECRETARY

When dignified propriety
Possesses your society,
Behind it is an intermediary,
Who has as his possession
Respect for our profession
And much of fine discression,
Our visionary, honorary,
Secretary.

When friction surreptitiously
Creeps in most inauspiciously,
And things begin to look incendiary;
With greatest erudition
And true to all tradition
He squelches that condition,
Our arbitrary, military,
Secretary.

With manner highly dignified
He does his tasks diversified,
He is the ultra-perfect functionary,
With charming personality,
Quite gracious hospitality,
And minus partiality,
Our customary, voluntary,
Secretary.

THE SECRETARY

Who is this guy with the lordly air
Who tells us when to head in and where
And fills our life full of sad dispair?
The wary, superciliary,
Secretary.

He chucks the President on the shelf
And runs our business to suit himself,
He hounds us always for hard earned pelf,
Pecuniary, mercenary,
Secretary.

He dictates all of our policy,
He spends our funds with a hand that's free,
For you or me not a damn cares he,
The biliary, adversary,
Secretary.

Within my sanctuary
I have a formulary
For an obituary,
To use when we can bury
That piece of statuary,
The usual stationary
Or wild reactionary
Secretary.

WOMEN

The women now trangress our every realm of work and play,
They work in all the factories and plants,
Play baseball, ride and swim,
Play golf, perform in gym,
And brazenly they wear our shirts and pants.

They take up all our mannerisms, habits, vices, clothes,
The transformation is beyond my ken,
Sophisticated, mannish,
All female traits now vanish,
In speech and work and play they're like the men.

I long to see a Woman's Senior Golf Association,
A plan that I consider keen and nifty,
But you will all agree
That this can never be,
No woman will admit she's over fifty.

THE PHILOSOPHY OF A FLAPPER

My life is all frivolity,
And I am full of jollity,
I'm all vivacity and never frown;
My inconsistent vanity
Drives old men to insanity,
I'm fickle and they call me thistle down.

I'm always gay with merriment
And revelry's my element,
Audacious piquant cleverness my line,
Each day a most entrancing one,
Each night a happy dancing one,
The gang assembled constitutes my shrine.

Let's make our life a merry one
With animation, mirth and fun,
Rejoice with joviality and cheer;
With spritely, jauntly liveliness,
With gay vivacious heedlessness,
Let's share the wild excitement always near.

Let's be sophisticated folks,
Not dreary educated jokes,
Impetuous capriciousness our aim,
We're bubbling effervescent ones,
We're troubling turbulescent ones,
Exhilirating cheerfulness we claim.

The world of fun's inviting us,
All pleasure is exciting us,
We live this life but once so it is said.
We'll live it fast and merrily,
We'll live it with hilarity,
Let's get life's thrill; we'll be a long time dead.